DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, Maryland 21244-1850

State Demonstrations Group

Nicole Comeaux
Director, Medical Assistance Division
New Mexico Human Services Department
State Capitol
Room 400
Santa Fe, NM 87501

Dear Ms. Comeaux:

The New Mexico Human Services Department submitted to CMS on April 25, 2019 the "Centennial Care Final Evaluation Report: 2014-2017." The report covers the demonstration period from January 1, 2014 through December 31, 2017. The submission is in accordance with the state's Special Terms and Conditions (STC) for the state's section 1115 demonstration (Project No. 11-W-00285/6), dated July 12, 2013, which requires a final evaluation report (STC #123). CMS appreciates the state's continued effort on evaluation activities.

In order to assess the effectiveness of the demonstration, the submitted evaluation report provides important quantitative data highlighting performance across a substantial number of performance and outcome metrics. For example, the report notes that the percent of beneficiaries completing an annual dental visit and the percent receiving adolescent immunizations both increased during the demonstration period. In addition, certain disease-specific care management metrics seem to have improved, as demonstrated by measures such as asthma controller medication compliance and HbA1c testing rates. Conversely, certain outcomes highlighted areas for improvement, as metrics such as antidepressant medication management, cervical and breast cancer screenings, and childhood immunizations all showed declines during the demonstration period. These outcomes, however, as the report has underscored, should be interpreted in the context of sharply expanding enrollment in the Centennial Care program. Notwithstanding these informative albeit largely descriptive findings, the evaluation report makes substantial departures from the state's approved evaluation design inhibiting the ability to make causal inferences about the impact of the demonstration. CMS identified potential areas for strengthening the report, and separately provided to the state constructive feedback with the expectation that the feedback would help inform the program's ongoing and future evaluation efforts.

In the meantime, on March 5, 2020 CMS received from the state a revised evaluation design for the Centennial Care 2.0 demonstration period, effective for the period of January 1, 2019 through December 31, 2023. This design incorporates more rigorous evaluation approaches that will

address many of the limitations identified in the evaluation report and highlighted in CMS's feedback on the report to the state. We further note that the evaluation design for the current period includes not only an assessment of the current demonstration period, but also a plan to look back and provide additional analysis for this previous demonstration period.

With these promising developments, CMS acknowledges the receipt of the "Centennial Care Final Evaluation Report: 2014-2017" and is posting it, along with other demonstration documents, on Medicaid.gov. In conformance with 42 CFR 431.424(e), it is required that the state will also make the report available on its state Medicaid website within 30 days.

We appreciate the state's cooperation and commitment to robust monitoring and evaluation of its current and future section 1115 demonstrations, and we look forward to continued collaboration.

If you have any questions, please contact your CMS project officer, Mr. Michael Trieger at 410-786-0745, or by email at Michael.Trieger1@cms.hhs.gov.

Sincerely,

Danielle Daly -S
Digitally signed by Danielle Daly -S
Date: 2020.03.12 04:27:33 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

Angela D. Garner -S
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Angela D. Garner
Director
Division of System Reform Demonstrations

cc: Peter Banks, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

Deloitte.

Centennial Care:

Evaluation Final Report

Demonstration Years 1 – 4:

January 2014 – December 2017

April 2019

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Executive Summary

New Mexico's Section 1115 Demonstration Waiver program, known as Centennial Care, was implemented to achieve the related goals of improved: access to care, coordinated care, quality of care, and member experience, while also reducing the growth trend in program expenditures. Although there is continued room for improvement in some areas, **the program has made substantial progress toward meeting each of the Demonstration goals**.

To assess the effectiveness of the waiver, over one hundred measures were assessed throughout the course of Centennial Care to determine if the results of the measures showed improvements relative to baseline values. For additional information, see the "Evaluation Plan Design" section.

Highlights from the final waiver evaluation, based on data through calendar year (CY) 2017, include:

- **Improving Access to Care –** The 1115 Waiver Evaluation noted improved progress in timely access to care across a wide range of measures as compared to the baseline[1] of the Centennial Care program. Increases were found in the percentage of state population enrolled in Centennial Care and the percentage of Native Americans opting into Centennial Care, indicating that those eligible for benefits are continuing to enroll. There was improvement in the ratio of members to providers, increased access to and utilization of telemedicine and use of mental health services (as indicated by members' principal diagnosis)[2], immunization rates for adolescents, the percentage of members utilizing newly available Behavioral Health (BH) services (BH respite, family support, and recovery services), and maintenance of high performance for annual dental visits.

  Conversely, declines were found in the percentage of adult members accessing preventive/ambulatory services, although the Demonstration Year (DY) 4 aggregate rate increased in a statistically significant fashion from DY3, the percentage of adult members receiving flu vaccinations, the percentage of adult and children members who had a Primary Care Physician (PCP) visit, the percentage of PCPs with open panels (though the overall percentage of open panels remained above 90% for three of four years), breast cancer screening rates, cervical cancer screening rates, childhood immunization rates, adolescent well care visits, and prenatal and postpartum care. These declines represent potential areas for continued focus in coming years, and in some cases were potentially affected by external factors such as the expansion of Medicaid and the influx of new members.

  It should be noted that a significant transition within the behavioral health provider network took place during 2015 (DY2). The State and managed care organizations (MCOs) made a concerted effort to expand capacity, including by supporting Federally Qualified Health Centers (FQHCs) to obtain the necessary certifications to offer specialized BH services. The State's efforts were intended to close network gaps and reduce the potential for service delays. Subsequent improvements in mental health services utilization and access to the new BH services (BH respite, family support, and recovery services) are indicative of the success of the State's efforts.

- **Improving Care Coordination and Integration –** The Evaluation documented general progress in both care coordination and integration activities. Improvements were noted in the percentage of members in Care Coordination Level 2 and 3 for whom a Comprehensive Needs Assessment (CNA) was performed and the percentage of long term services and supports (LTSS) members who also utilized a BH service. In addition, there was a favorable decline in

[1] 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.
[2] This HEDIS measure is based on the Mental Health Value Set, which does not include diagnoses or services related to Substance Use Disorders.

the percentage of Emergency Room (ER) visits that were potentially avoidable among members in Care Coordination Levels 2 and 3 and the ER visit rates among members with BH needs declined.

There has been an increase in the number of unique members with BH needs receiving Home and Community-Based services (HCBS), and an overall increase in HCBS utilization among all members. New Mexico continues to be successful in its rebalancing efforts, with 85.6% of long-term care members receiving long-term services and supports in their homes in DY4 and only 14.4% of members receiving services as residents of nursing facilities.

Conversely, a lower percentage of LTSS members received a PCP visit, a higher percentage of LTSS members had ER visits, a lower percentage of members with schizophrenia or bipolar disorder received diabetes screening, and a greater percentage of members refused care coordination.

- **Improving Quality of Care –** The Evaluation found continued improvements in quality of care. There were improvements in monitoring rates of Body Mass Index (BMI) for adults, children, and adolescents; increases in medication management for people with asthma; and improvement in asthma medication ratios. Hospital admission rates also decreased across all six ambulatory care sensitive (ACS) components: hypertension, pediatric asthma, diabetes admissions related to short term and long-term complications, and Chronic Obstructive Pulmonary Disease (COPD)/asthma in older adults and younger adults (four measures in total). Finally, there was a decline in the percentage of potentially avoidable ER visits.

- **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 DY4. Total program expenditures for DY4 alone were 28.1% below the budget-neutral limits as defined by the Special Terms and Conditions (STCs)[3], which includes per member per month (PMPM) cost caps by Medicaid Eligibility Group (MEG), uncompensated care (UC) costs, and Hospital Quality Improvement Incentive (HQII) pool amounts. The total PMPM costs of Centennial Care decreased in absolute terms from DY1 to DY4, declining by 4% across all MEGs.

  Program savings were driven in part by the transition to less costly services, including greater utilization of outpatient substance abuse services, an increase in the use of HCBS (i.e., rebalancing of LTSS), positive shifts in pharmacy utilization where usage of generic drugs is more prevalent than brand drugs, and continued reduction in inpatient claims exceeding $50,000 as a percentage of healthcare costs.

- **Increased Member Engagement** – There was a significant increase in the number of members who enrolled in the Centennial Rewards program and performed 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. As of Q3 of DY4, approximately 245,000, or 26.2% 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 DY4. In addition, the percentage of eligible members earning rewards was just over 40% through DY1 but increased to over 72% by DY4.

  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

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

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 DY4 and improved since Interim reporting. Measures that exhibited improvements included rating of personal doctor, rating of specialist seen most often, and rating of health care. The percentage of appeals upheld, partially overturned, and overturned (favorable decline) also experienced improvements. Satisfaction rates for care coordination and customer service satisfaction rates also increased for members from the baseline to DY4.

When reading the contents of this report in detail, it is important to understand that total Centennial Care member months increased from DY1 to DY4 by about 1,471,000, or 21.5%[4]. The vast majority of this increase was driven by MEG 6, (named "VIII Group"), which is the Medicaid adult expansion group. Enrollment in VIII Group grew by 66.5% from DY1 to DY4. 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 had significant impacts on the results of various measures as the members participating in Centennial Care in DY2 through DY4 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.

[4] Based on member month figures according to the budget neutrality tables for DY1, DY2, DY3, and DY4.

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 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 (PH), behavioral health (BH) and LTSS. 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 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 Final 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 additional program data becomes available and the program matures under Centennial Care 2.0.

[5] STC 123: Final Evaluation Report.

Evaluation Plan Design

Consistent with the STCs from CMS, Deloitte Consulting LLP (Deloitte) conducted this Evaluation to study New Mexico's performance operating the waiver program following the approved Evaluation Plan Design. This Final Report covers program operations from January 1, 2014 through December 31, 2017 (DY4).

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

The Human Services Department, Medical Assistance Division (HSD/MAD) 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 was to track performance of each Centennial Care evaluation measure over time against a baseline value.

For this Final Report on the Centennial Care demonstration, each of these performance measures was 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. In addition, the performance measures were compared to other meaningful points of reference, including but not limited to:

- Measure values for prior demonstration years, such as progress in DY4 compared to DY3 and DY3 compared to DY2 etc., 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 Final 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 is 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 and Evaluation Limitations

Consistent with HSD/MAD'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/MAD 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.

Prior to January 1, 2014, HSD/MAD 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

[6] National benchmarks for CAHPS measures obtained through NCQA's Quality Compass (QC) tool referenced in this report uses data captured in calendar year 2017 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, are provided as a point of reference. SPH benchmarks are based on data captured in calendar year 2017 for a subset of qualified providers nationwide.

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, or Deloitte worked with HSD/MAD 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. Incurred But Not Reported 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.
- 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 and thus there is an implication that seasonality has a limited impact.
- 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 their audited HEDIS reports 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 reporting period; these are footnoted in the detailed measure results.
- 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 due to the unavailability of complete data.

- 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/MAD to identify the errors and suggested requested updated reports for future reporting cycles.
- There have been various challenges in collecting Care Coordination data over the course of Centennial Care. These challenges included non-standardized counting/reporting methodologies as well as systematic limitations experienced amongst the MCOs. Deloitte worked with HSD/MAD to address these issues as they arose and ultimately determined that DY1 and DY2 would not be included in the analysis for measures 30 and 31 due to concerns surrounding the integrity of the data collected. In addition, the following Care Coordination measures were removed from Research Question 2A due to the aforementioned data integrity issues:
    - Measure 28 – Number and percentage of participants with health risk assessments completed within contract timeframes;
    - Measure 29 – Number and percentage of participants who received a care coordination designation and assignment of care coordinator within contract timeframes;
    - Measure 32 – Number and percentage of participants in care coordination Level 2 who received in-person visits and telephone contact within contract timeframes;
    - Measure 33 – Number and percentage of participants in care coordination Level 3 who received in-person visits and telephone contact within contract timeframes; and
    - Measure 34 – Number and percentage of participants the MCO is unable to locate for care coordination.

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 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 declined 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 BHSE.

The Evaluation is reviewing Centennial Care's impact on service delivery and integration through the analysis of 12 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 DY4 of the Centennial Care program, programmatic performance generally showed improved access to care. There were positive performance results when compared to the baseline in eight out of 12 measures.

While an increasingly higher percentage of state population is enrolling in Centennial Care, and a greater percentage of Native Americans are participating in the program, New Mexico saw increases from the baseline to DY4 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 Nursing Facility Level of Care (NF LOC) designation received care through the community, and a lower percentage of those members received care in Nursing Facilities (NFs). Finally, mental health services utilization increased, a larger number of providers participated in Centennial Care in DY4 compared to DY1, and the member-to-provider ratio experienced a favorable decrease.

There was a decline in three out of 12 measures from the baseline to DY4. These results included a lower percentage of adult enrollees that utilized preventive or ambulatory services, although the DY4 aggregate rate increased in a statistically significant fashion compared to DY3, a lower percentage of children and adult members had at least one visit to a PCP, and a lower percentage of PCPs reported open panels in their practices (though the overall percentage of open panels remained above 90% for three out of four years of Centennial Care).

One measure experienced relatively consistent performance from the baseline to DY4, namely the percentage of children and young adults that received dental visits. Although a measurable improvement since the baseline was not achieved, DY4 experience of members receiving dental visits was significantly higher than 2017 HEDIS national averages for each age cohort.

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

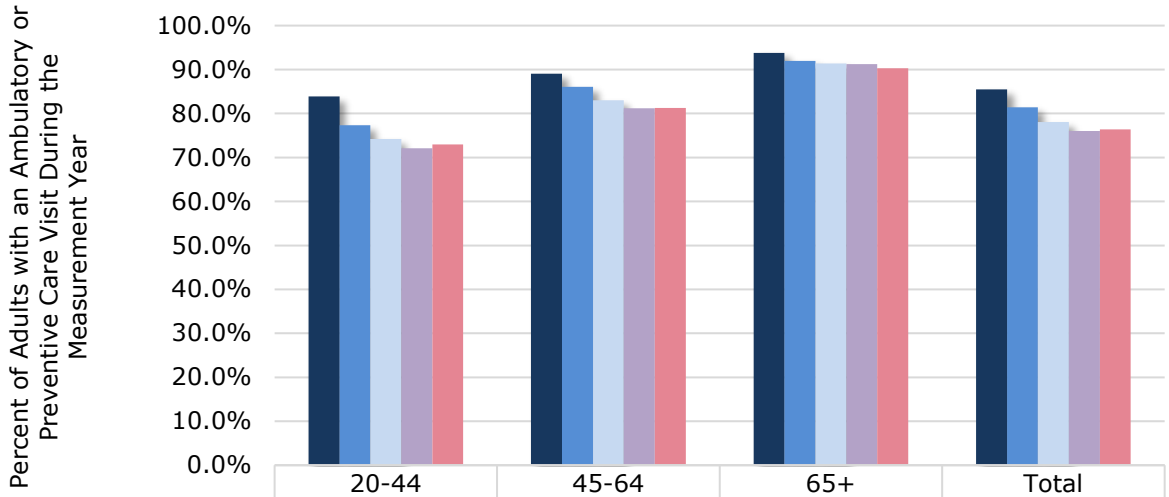
Exhibit 1 presents rates for the 2013 baseline through DY4 for the measure Access to Ambulatory/Preventive Care. As illustrated, the percentages for the 20-44 and 45-64 age cohorts as well as the aggregate percentage experienced an increase from DY3 to DY4, while the 65+ age cohort decreased. The annual changes for the 20-44 and 65+ age cohorts as well as in aggregate were statistically significant at the 95% confidence level while the change for the 45-64 age cohort was not statistically significant.

Upon review of the individual MCO performance, UHC experienced the largest change in the aggregate rate (-2.4%) from DY3 to DY4 compared to BCBS, MHC, and PHP, which experienced changes of 2.1%, 2.0%, and -0.4% respectively.

The percentages for each of the three age cohorts as well as the aggregate percentage declined from the baseline to DY4 and were statistically significant. The aggregate rate declined 10.6%, and all of the changes for the age cohorts and the aggregate percentage were statistically significant. All four MCOs experienced decreases from the baseline to DY4 for the aggregate percentage.

A national comparison 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%
DY3 Centennial Care	72.1%	81.2%	91.3%	76.0%
DY4 Centennial Care	73.0%	81.3%	90.3%	76.4%

[7] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measure "aap").
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.

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

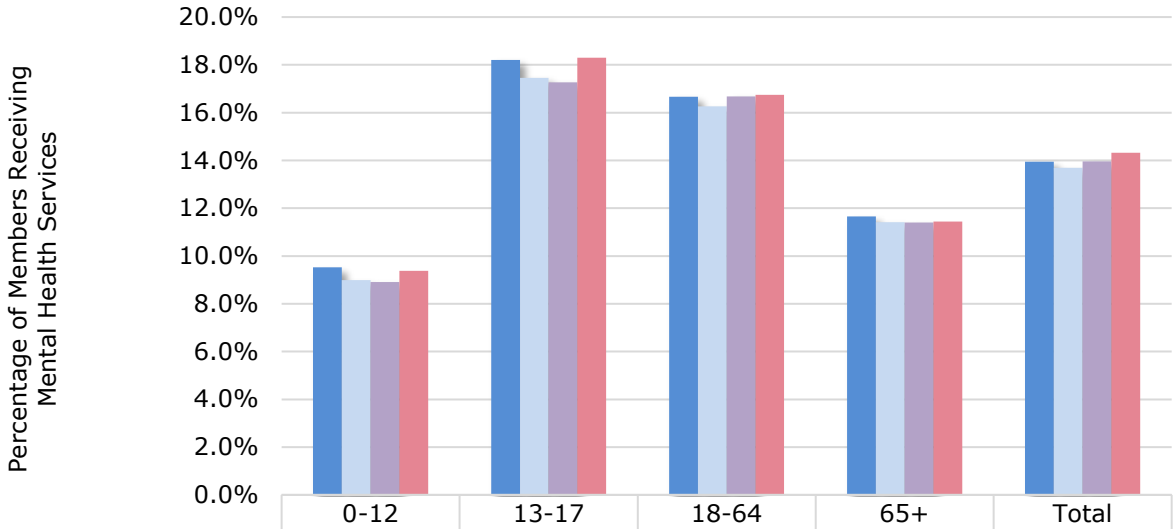
Exhibit 2 presents rates for DY1 through DY4 for mental health services utilization. As illustrated, the percentages for two age cohorts (0-12 and 13-17) as well as the aggregate percentage experienced an increase from DY3 to DY4. The percentages for the remaining two age cohorts (18-64 and 65+) remained consistent from DY3 to DY4. The largest increase among the age cohort subcomponents was experienced in the 13-17 years of age cohort which increased from 17.3% in DY3 to 18.3% in DY4 (a 6.0% increase). Annual increases for the 0-12 age cohort, 13-17 age cohort, and the aggregate percentage were statistically significant at the 95% confidence level.

BCBS, MHC, and PHP each experienced an increase in the aggregate percentages of 5.2%, 5.1%, and 3.0% respectively from DY3 to DY4. UHC experienced a decrease in the aggregate percentage of 7.6% from DY3 to DY4. All changes were statistically significant at the 95% confidence level.

The 0-12 age cohort and 65+ age cohort experienced slight declines from DY1 to DY4, while the 13-17 age cohort and 18-64 age cohort experienced slight increases from DY1 to DY4. The aggregate percentage experienced a statistically significant increase of 2.8% from DY1 to DY4.

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%
DY3 Centennial Care	8.9%	17.3%	16.7%	11.4%	14.0%
DY4 Centennial Care	9.4%	18.3%	16.7%	11.4%	14.3%

[8] Source: MCO annual HEDIS reports for 2014 – 2017 (HEDIS Measure "mpta").
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.

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

Exhibit 3 presents results for the 2013 baseline through DY4 for the measure Telemedicine Utilization (Number of Telemedicine Providers and Telemedicine Utilization).

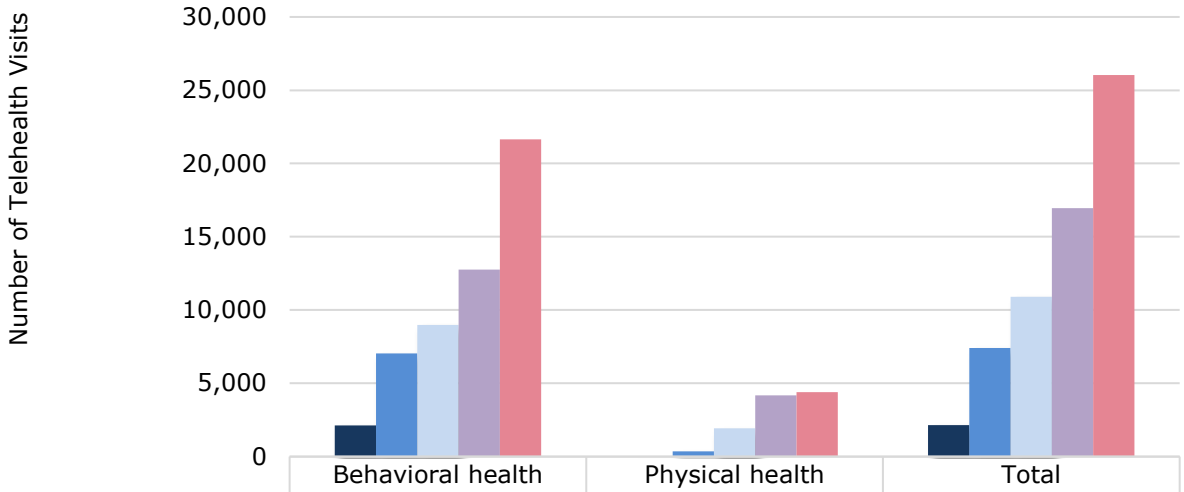
As illustrated, utilization of telemedicine increased in both PH (5.4%) and BH (69.4%) subcomponents as well as in aggregate (53.6%) from DY3 to DY4. The 8.9K increase in behavioral health telemedicine visits was likely a contributing factor to the overall increase in mental health services utilization from DY3 to DY4 as depicted in Measure 2 results.

Upon review of the MCOs during the same reporting period, UHC, PHP and MHC all experienced increases in the aggregate at 137.2%, 93.4% and 20.5% respectively. UHC experienced the largest percentage increase in behavioral health at 161.1% while MHC experienced the largest percentage increase in physical health at 123.5%.

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
DY3 Centennial Care	12,772	4,181	16,953
DY4 Centennial Care	21,641	4,405	26,046

[9] Source: Ad hoc MCO reports 2013 - 2017.
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.

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 Community Benefit (CB) service package. Under the former CoLTS program, individuals who were Medicaid eligible could receive PCS under the state plan and were required to wait for a waiver allocation to have access to the full array of CoLTS HCBS. Under Centennial Care, Medicaid members have access to all CB services for which an assessment indicates need, without an allocation, upon meeting the NF LOC criteria. Individuals who do not meet full Medicaid financial eligibility requirements may be allocated to a waiver "slot".

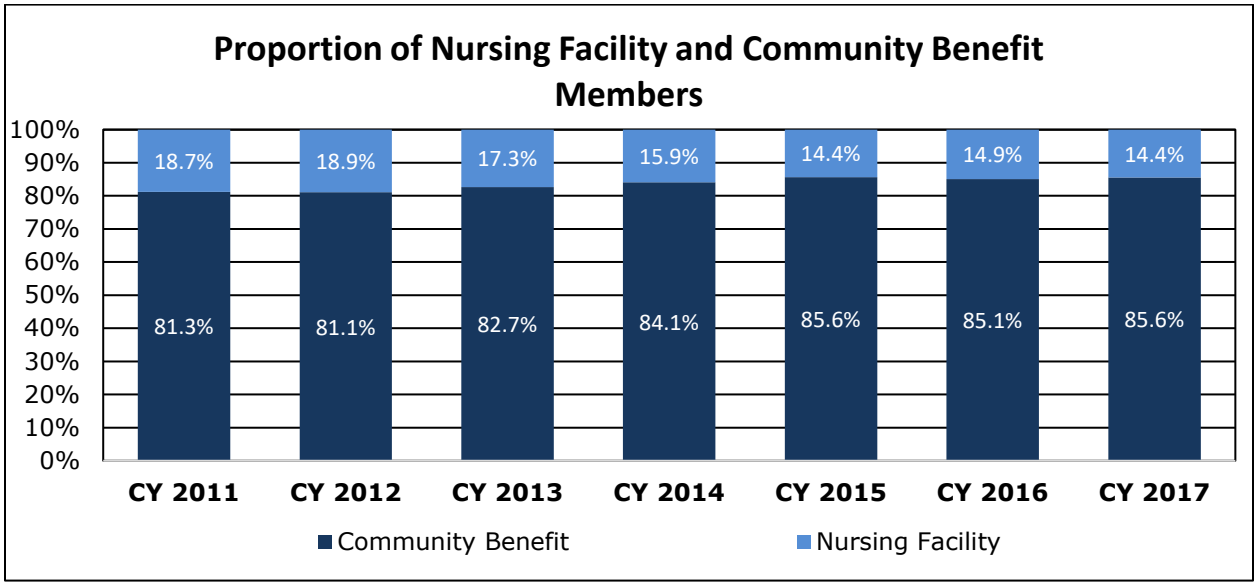
The percentage of members who meet NF LOC and are receiving HCBS increased 0.6% from DY3 to DY4. Over the course of Centennial Care, the percentage of members who meet NF LOC and are receiving HCBS increased 3.5% compared to the 2013 baseline.

In overall performance of its LTSS program, New Mexico ranks in the second-best quartile in the 2017 National State Long-Term Care Scorecard published by the AARP and the Commonwealth Fund. New Mexico's Long Term Care (LTC) system is especially strong in terms of:

- Choice of setting and provider (top quartile)
- Effective transitions across settings of care (second quartile)

Under Centennial Care, NM has continued to reintegrate members from nursing facilities into the community, with 85.6% of members in the LTC program being served in the community in 2017, which is relatively consistent with 2016 results.

Exhibit 4.a/5.a – LTSS Enrollment - Dual and Medicaid Only NF LOC Enrollment Proportion[10]



In addition in the AARP's annual report for 2017, *State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities and Family Caregivers*, New Mexico ranks third in the nation for the percentage of total long-term care dollars spent on home and community-

[10] Source: Ad hoc report developed by the State's actuary 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.

based services and third in the nation for the percentage of new Medicaid aged/disabled LTSS members first receiving services in the community setting.

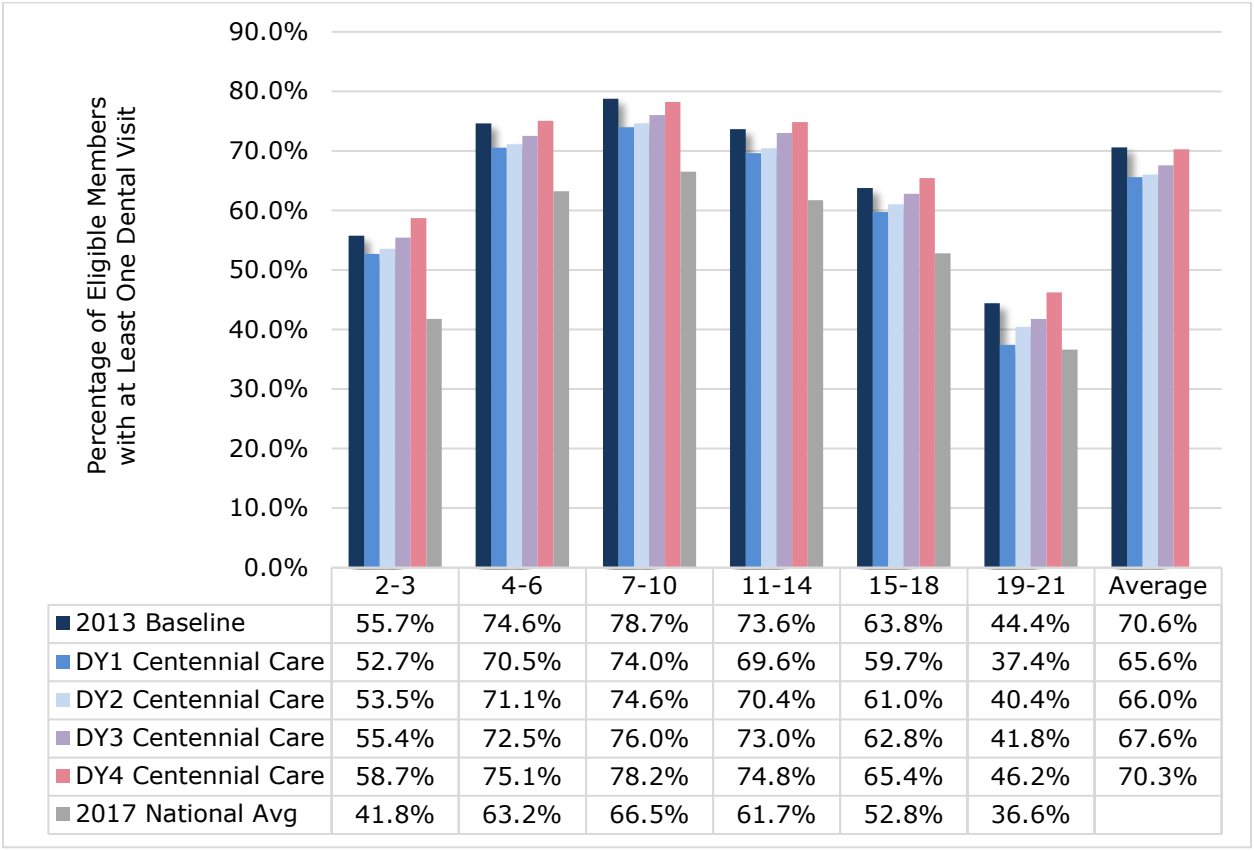
Measure 6 – Number and percentage of people with annual dental visit.

Exhibits 6.a and 6.b present rates for the 2013 baseline through DY4 and the 2017 HEDIS Medicaid national average for the Percentage and Number of Members with an Annual Dental Visit. As illustrated, the aggregate percentage increased 3.9% from DY3 to DY4. All age cohorts increased from DY3 to DY4 with the 19-20 age cohort experiencing the largest increase of 10.6%. All percentage changes were statistically significant at a 95% confidence level.

Each of the four MCOs experienced an aggregate percentage increase from DY3 to DY4. UHC experienced the largest increase at 13.2%. MHC, BCBS, and PHP experienced increases of 4.6%, 4.2%, and 2.7% respectively. The subcomponent that experienced the largest increases for three of the four MCOs was the 19-20 age cohort.

The aggregate percentage experienced a decline of 0.4% from the baseline to DY4, which was statistically significant at the 95% confidence level. Despite this small decline, it is important to note that Centennial Care's DY4 experience was significantly higher than the 2017 HEDIS national averages for each age cohort.

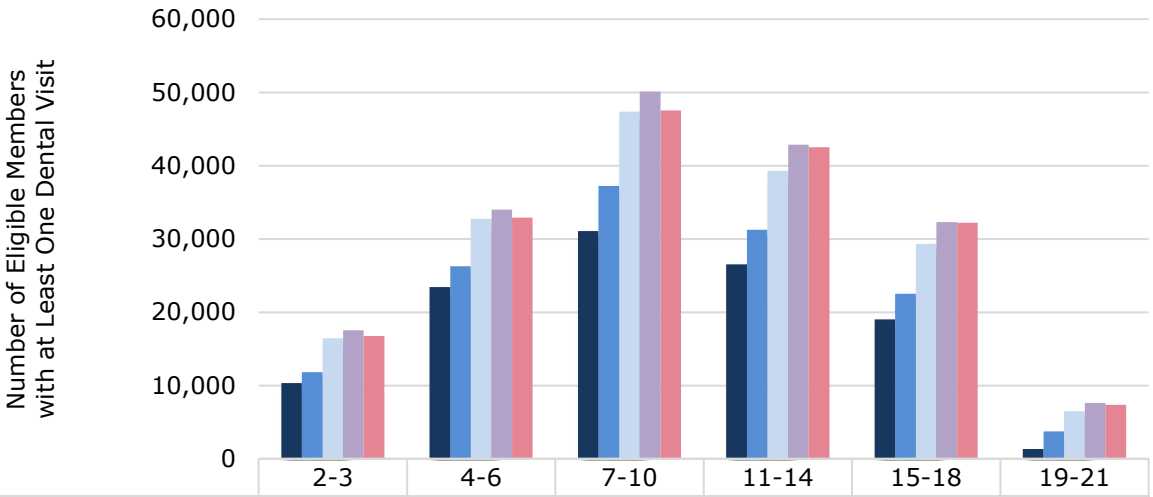
Exhibit 6.a – Percentage of Participants with Annual Dental Visits by Age Group[11]



	2-3	4-6	7-10	11-14	15-18	19-21	Average
2013 Baseline	55.7%	74.6%	78.7%	73.6%	63.8%	44.4%	70.6%
DY1 Centennial Care	52.7%	70.5%	74.0%	69.6%	59.7%	37.4%	65.6%
DY2 Centennial Care	53.5%	71.1%	74.6%	70.4%	61.0%	40.4%	66.0%
DY3 Centennial Care	55.4%	72.5%	76.0%	73.0%	62.8%	41.8%	67.6%
DY4 Centennial Care	58.7%	75.1%	78.2%	74.8%	65.4%	46.2%	70.3%
2017 National Avg	41.8%	63.2%	66.5%	61.7%	52.8%	36.6%	

[11] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measure "adv").
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.

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



	2-3	4-6	7-10	11-14	15-18	19-21
2013 Baseline	10,334	23,429	31,095	26,554	19,034	1,352
DY1 Centennial Care	11,805	26,278	37,225	31,248	22,520	3,752
DY2 Centennial Care	16,429	32,733	47,378	39,301	29,346	6,476
DY3 Centennial Care	17,542	34,011	50,100	42,867	32,319	7,619
DY4 Centennial Care	16,774	32,924	47,546	42,498	32,222	7,358

[12] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measure "adv").
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.

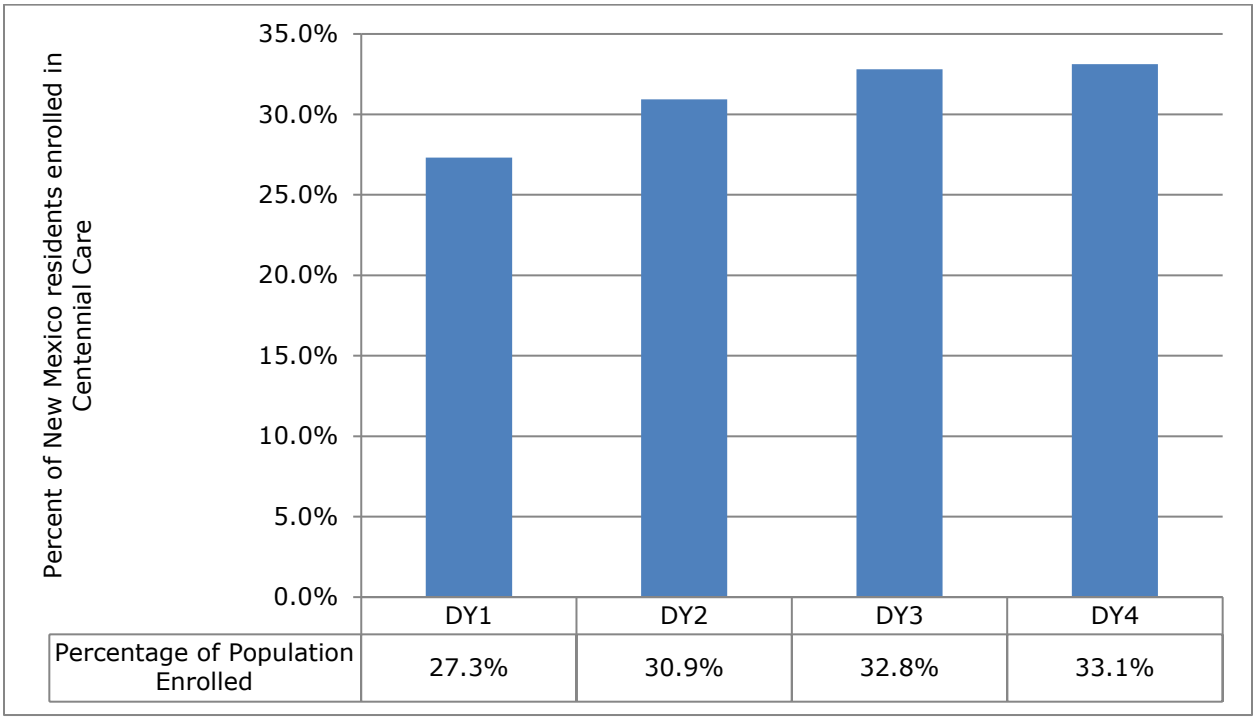
Measure 7 – Enrollment in Centennial Care as a percentage of state population.

Exhibit 7 presents the results for DY1 through DY4 for the percentage of the population enrolled in Centennial Care as well as year-over-year enrollment growth in Centennial Care.

As illustrated, the percentage of New Mexicans enrolled in Centennial Care has increased by 1.0% from DY3 to DY4, and has experienced annual growth each year of the program. The total program-to-date increase in the percentage of New Mexico's population enrolled in Centennial Care was 21.3% from DY1 to DY4, 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	DY4
Percentage of Population Enrolled	27.3%	30.9%	32.8%	33.1%

[13] Source: Dashboard reports for Centennial Care enrollment developed by the State's actuary and United States Census Bureau annual state level population estimates as of July 1, 2017. Note that prior demonstration years have been updated with most recent data dashboard data available.
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.

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

Exhibit 8 presents the results for DY1 through DY4 for the Number of Native Americans that Opt-out of Centennial Care.

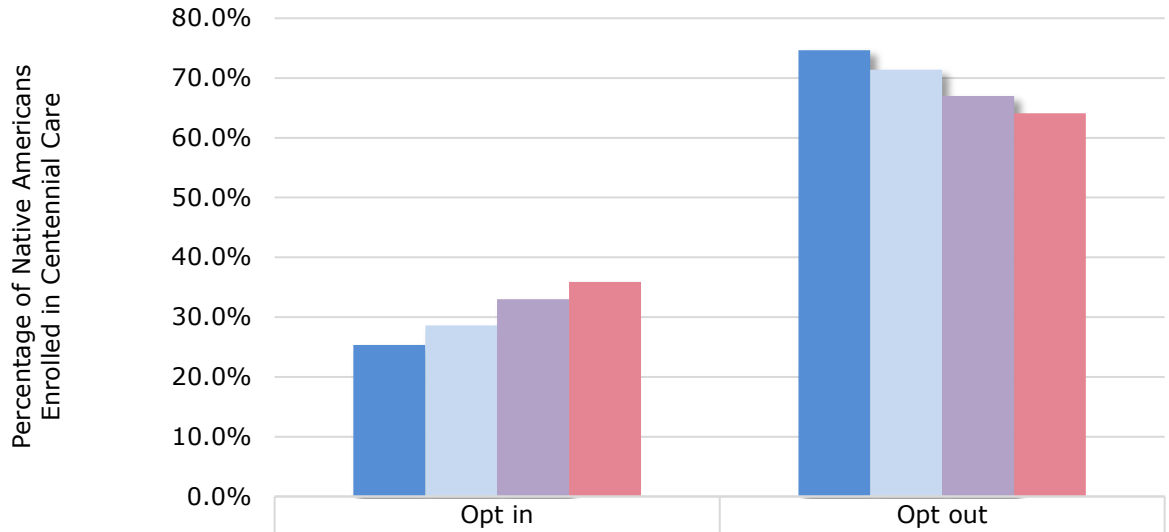
As illustrated, the percentage of Native Americans' who opted-in to Centennial Care increased by 8.8% and the percentage of members opting-out decreased 4.3% from DY3 to DY4.

Overall the percentage of Native Americans' who opted-in increased by 41.7% and the percentage of members opting-out decreased by 14.2% from DY1 to DY4.

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%
DY4 Centennial Care	35.9%	64.1%

[14] Source: Native American Opt In reports for 2014 – 2017.
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.

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).

Exhibits 10.a and 10.b present rates for DY1 through DY4 for the utilization of new BH services as well as the number of participants who accessed these services. The three new services were not fully operational in DY1 and DY2 and there are several considerations with respect to the results:

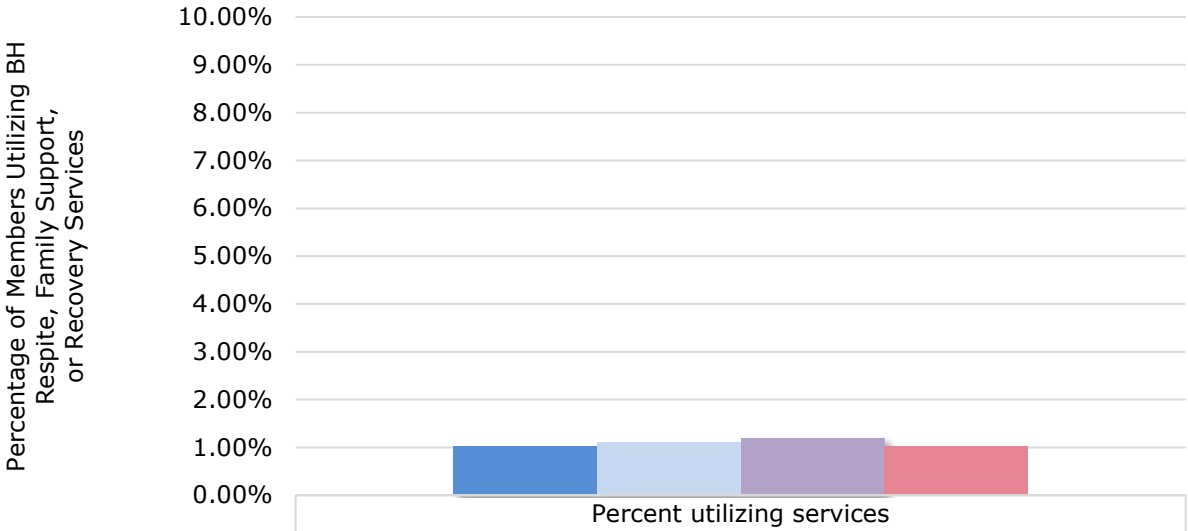
- The Family Support Services were not launched during this review period as the Family Certification program was being built to train qualified staff. In DY4, the certification began in January 2018 for families of children and for families of adults. The existing Certified Peer Support Worker certification 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 were made available individually for adults.

As illustrated, utilization of the new services decreased from 1.20% in DY3 to 1.02% in DY4 (a change of 14.4%), which was statistically significant at the 95% confidence level.

The utilization of the new services remained relatively consistent at 1.02% from DY1 to DY4.

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

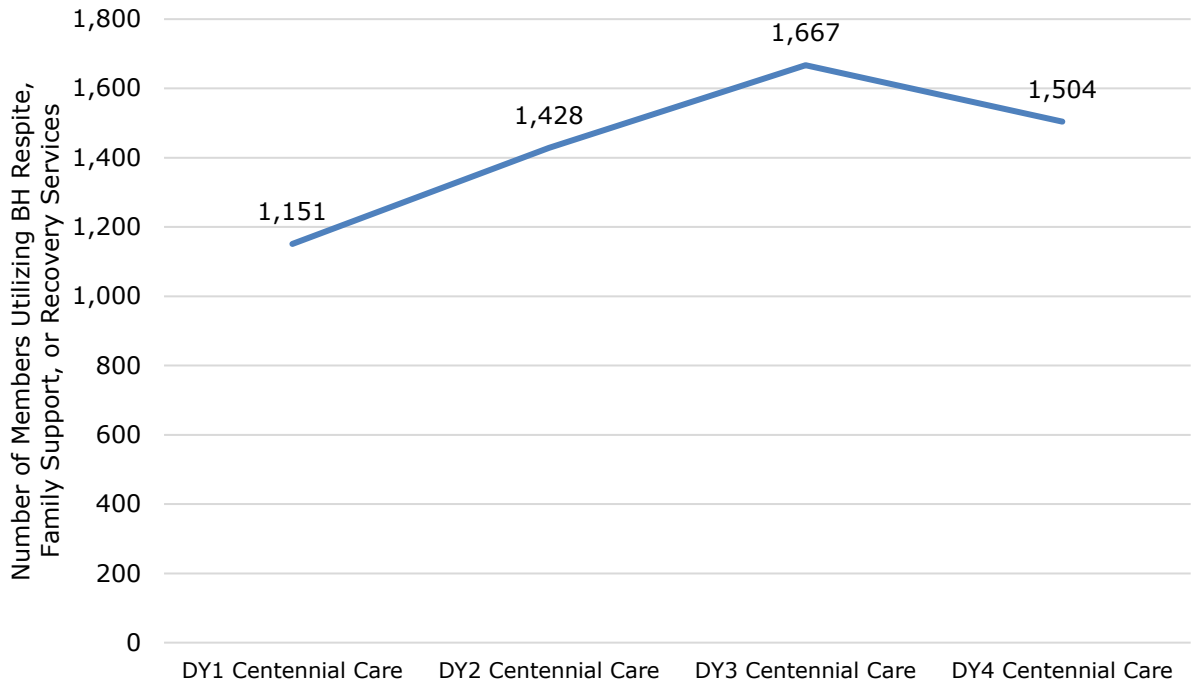
Exhibit 10.a – Members Utilizing BH Respite, Family Support, and Recovery Services[15]



	Percent utilizing services
DY1 Centennial Care	1.02%
DY2 Centennial Care	1.10%
DY3 Centennial Care	1.20%
DY4 Centennial Care	1.02%

[15] Source: BH Clients with Respite, Family Support, Recovery Services MMIS reports for 2013 – 2017. Note that claims analysis criteria was revised between DY2 and DY3 to account for the ICD-9 changeover to ICD-10.
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.

Exhibit 10.b – Number of Members Utilizing BH Respite, Family Support, and Recovery Services[16]



[16] BH Clients with Respite, Family Support, Recovery Services MMIS reports for 2013 – 2017. Note that claims analysis criteria was revised between DY2 and DY3 to account for the ICD-9 changeover to ICD-10.

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

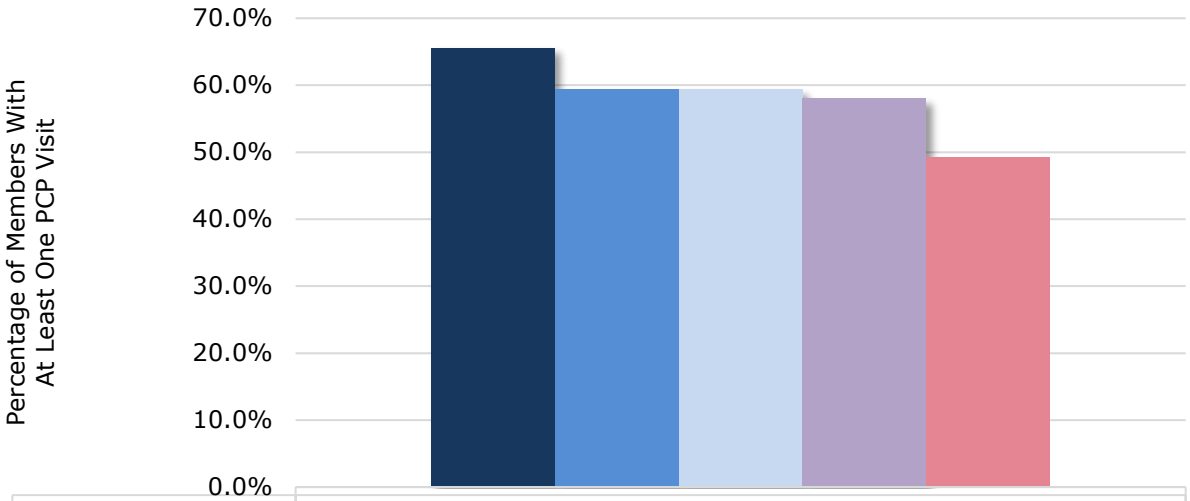
Exhibits 11.a and 11.b present results for DY1 through DY4 for the Access to PCP measure. As illustrated, the percentage of members with at least one PCP visit decreased 15.0% from DY3 to DY4, which was statistically significant at the 95% confidence level.

From the baseline year through DY4, the percentage of members with at least one PCP visit decreased 24.8%, which was statistically significant at the 95% confidence level.

It should be noted that the large annual enrollment increases may have contributed to the lower percentage of members with at least one PCP visit.

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

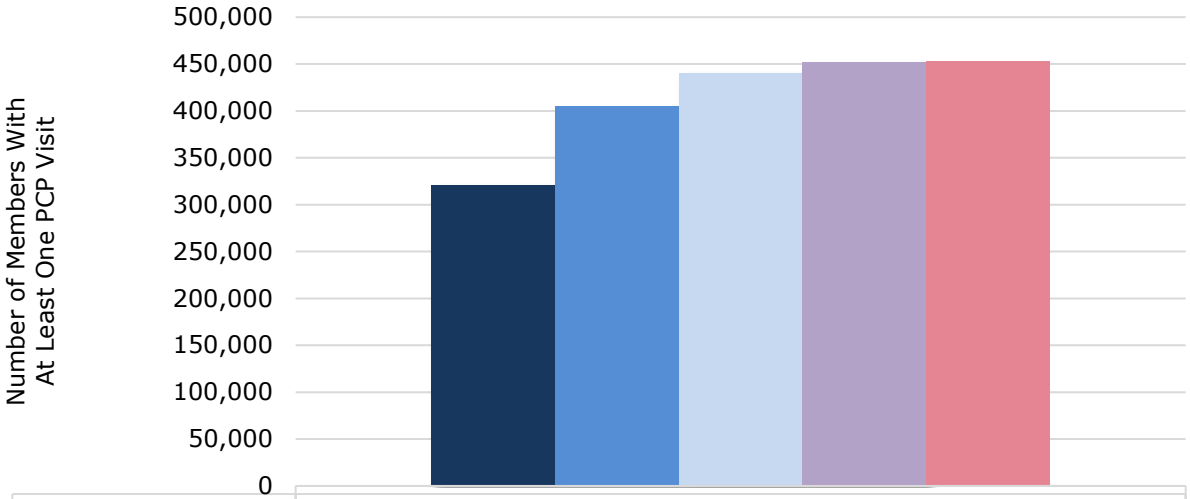
Exhibit 11.a – Percentage of Members with at Least One PCP Visit[17]



2013 Baseline	65.5%
DY1 Centennial Care	59.3%
DY2 Centennial Care	59.3%
DY3 Centennial Care	58.0%
DY4 Centennial Care	49.3%

[17] Source: PCP Visits MMIS reports for 2013 – 2017. Note that claims analysis criteria was revised between DY2 and DY3 to account for the ICD-9 changeover to ICD-10. In addition, historic information was refreshed in March of 2019 to capture all claims run-out for historic periods. 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.

Exhibit 11.b – Number of Members with at Least One PCP Visit[18]



2013 Baseline	320,749
DY1 Centennial Care	404,794
DY2 Centennial Care	440,115
DY3 Centennial Care	451,355
DY4 Centennial Care	452,631

[18] Source: PCP Visits MMIS reports for 2013 – 2017. Note that claims analysis criteria was revised between DY2 and DY3 to account for the ICD-9 changeover to ICD-10. In addition, historic information was refreshed in March of 2019 to capture all claims run-out for historic periods. 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.

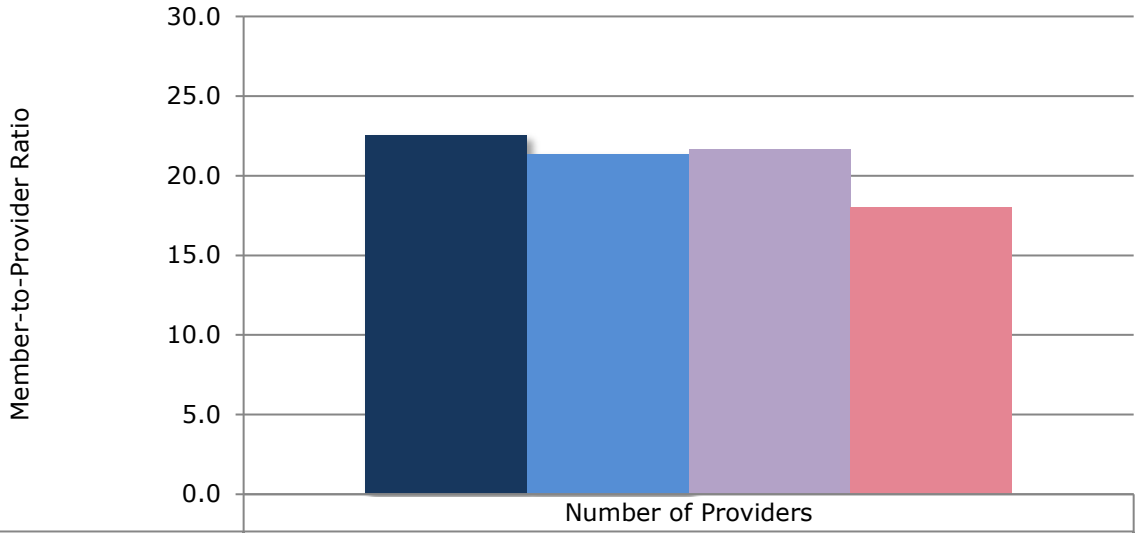
Measure 12 – Number/ratio of participating members to providers.

Exhibit 12.a presents results for DY1 through DY4 for the ratio of members to providers, and Exhibit 12.b provides the Number of Providers. As illustrated, the ratio of members to providers experienced a favorable decrease from 21.6 in DY3 to 18.0 in DY4 (a 16.7% change). This decrease in the ratio was driven by a 21.4% increase in the number of providers participating in Centennial Care, which increased from approximately 32K in DY3 to approximately 38K in DY4.

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

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

Exhibit 12.a – Ratio of Members to Participating Providers[19]

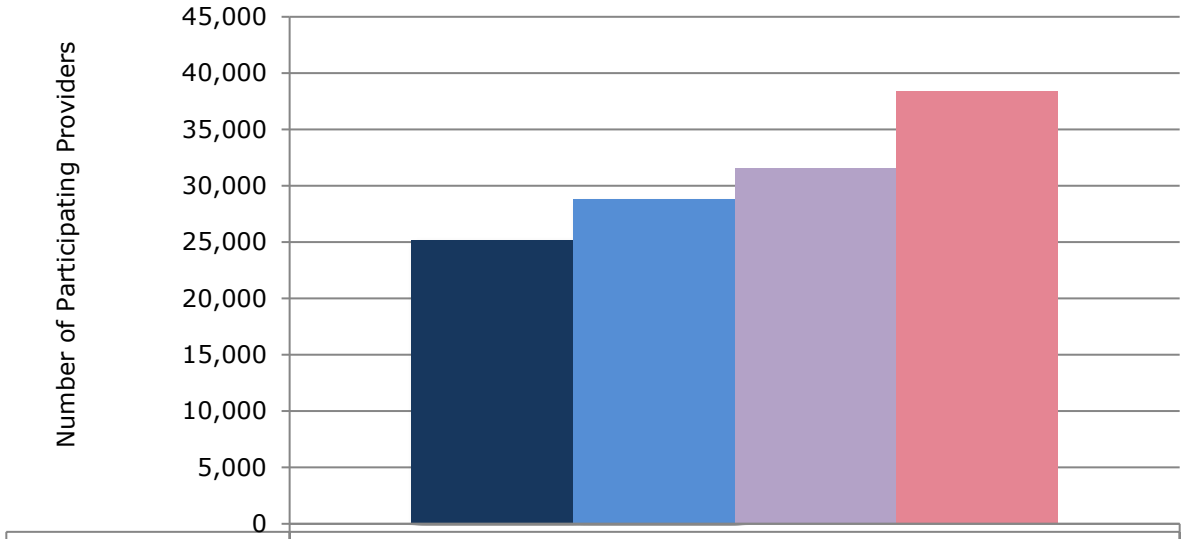


	Number of Providers
DY1 Centennial Care	22.6
DY2 Centennial Care	21.4
DY3 Centennial Care	21.6
DY4 Centennial Care	18.0

[19] Source: MCO reports for 2014 – 2017 (HSD/MAD 3).

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.

Exhibit 12.b – Number of Participating Providers[20]



DY1 Centennial Care	25,217
DY2 Centennial Care	28,791
DY3 Centennial Care	31,601
DY4 Centennial Care	38,365

[20] Source: MCO reports for 2014 – 2017 (HSD/MAD 3).

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.

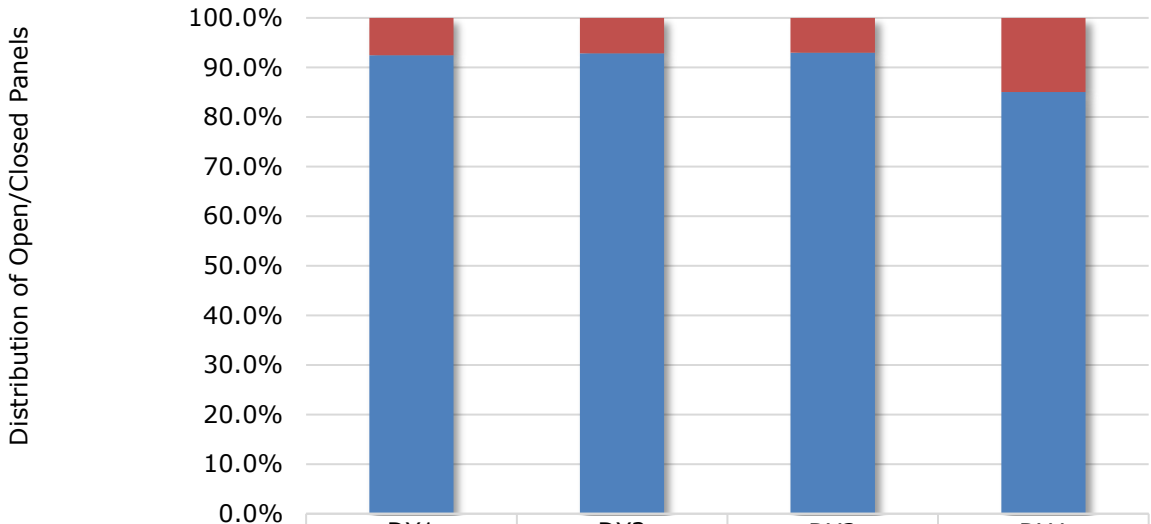
Measure 13 – Percentage of primary care providers with open panels.

Exhibit 13 presents rates for DY1 through DY4 for PCPs with Open Panels. For this measure, 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. Based on the data available, the percentage of open panels declined 8.6% from DY3 to DY4. Similarly, the percentage of open panels decreased 8.0% from DY1 to DY4. Despite these changes, the overall percentage of open panels was over 90.0% for DY1 through DY3.

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[21]



	DY1 Centennial Care	DY2 Centennial Care	DY3 Centennial Care	DY4 Centennial Care
Closed panel percentage	7.5%	7.1%	7.0%	15.0%
Open panel percentage	92.5%	92.9%	93.0%	85.0%

[21] Source: MCO reports for 2014 – 2017 (HSD/MAD 3). Note that the DY1 open/closed distribution reported in the Interim report did not correctly capture the average annual open/closed distribution for one of the MCOs and has since been corrected. 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.

Research Question 1.B

Is access to care timely under Centennial Care?

The Evaluation reviewed 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 DY4 of Centennial Care, programmatic performance declined across ten of 14 performance measures. Despite the declines, there were still some improvements in measure results between Interim Reporting and Final Reporting.

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 DY4 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; in addition, the large enrollment increase may have affected well-child and adolescent visit rates and rates of other screenings and immunizations that are generally checked and provided during an annual PCP visit.

Two measures demonstrated clear improvement, including immunizations for adolescents, which showed improvement across all three subcomponents; and Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, which showed improved results across both subcomponents.

Plan by plan comparisons were examined in place of aggregate rates for the measure Well-Child Visits in the First 15 Months of Life due to differences in data reporting methodologies across MCOs. Performance trends were mixed across MCOs for this measure.

Ten of the 14 measures demonstrated a decline in performance. Rates decreased for timely follow-up after leaving an RTC, timely follow-up after hospitalization for mental illness (although DY4 results exceeded national averages), childhood immunization, adults receiving flu vaccinations (although DY4 results exceeded national averages), 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, Well-Child Visits in Third, Fourth, Fifth, and Sixth Years of Life exhibited declines (three of four MCOs) and there were observed shifts from the highest frequency to lower frequencies of visits for 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.

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

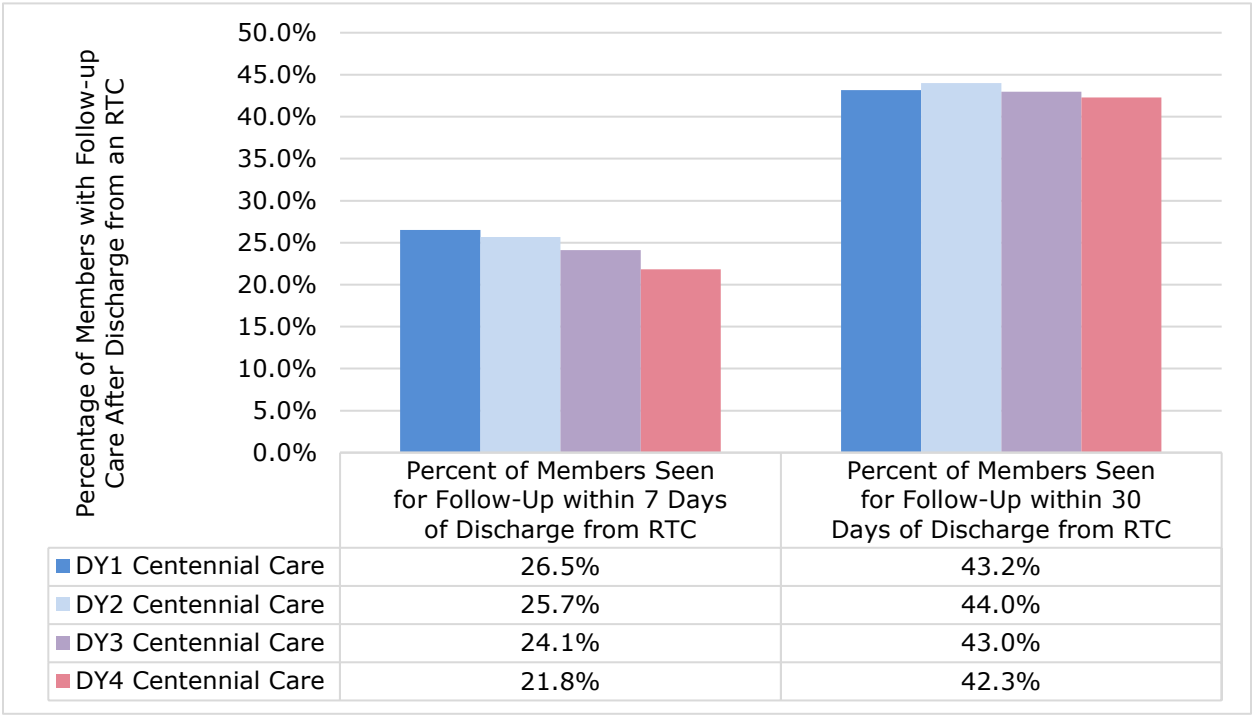
Exhibits 14.a and 14.b present results for DY1 through DY4 for the Percentage and Number of Substance Use Disorder Participants who received Follow-up 7 and 30 Days after leaving a RTC. RTCs serve the youth population with a substance use disorder who are under the age of 21 and enrolled in Centennial Care.

As illustrated, the percentage of members who received follow-up care after they were discharged from an RTC declined 9.5% for the 7-day subcomponent and 1.6% for the 30-day subcomponent from DY3 to DY4. Neither of these declines were statistically significant at the 95% confidence level.

Similarly, declines were experienced for both the 7-day (-17.6%) and 30-day (-2.0%) subcomponents from DY1 to DY4. This decline was driven by poor experience for PHP in both subcomponents. Neither of these declines were statistically significant at the 95% confidence level.

A national comparison could not be identified for this measure.

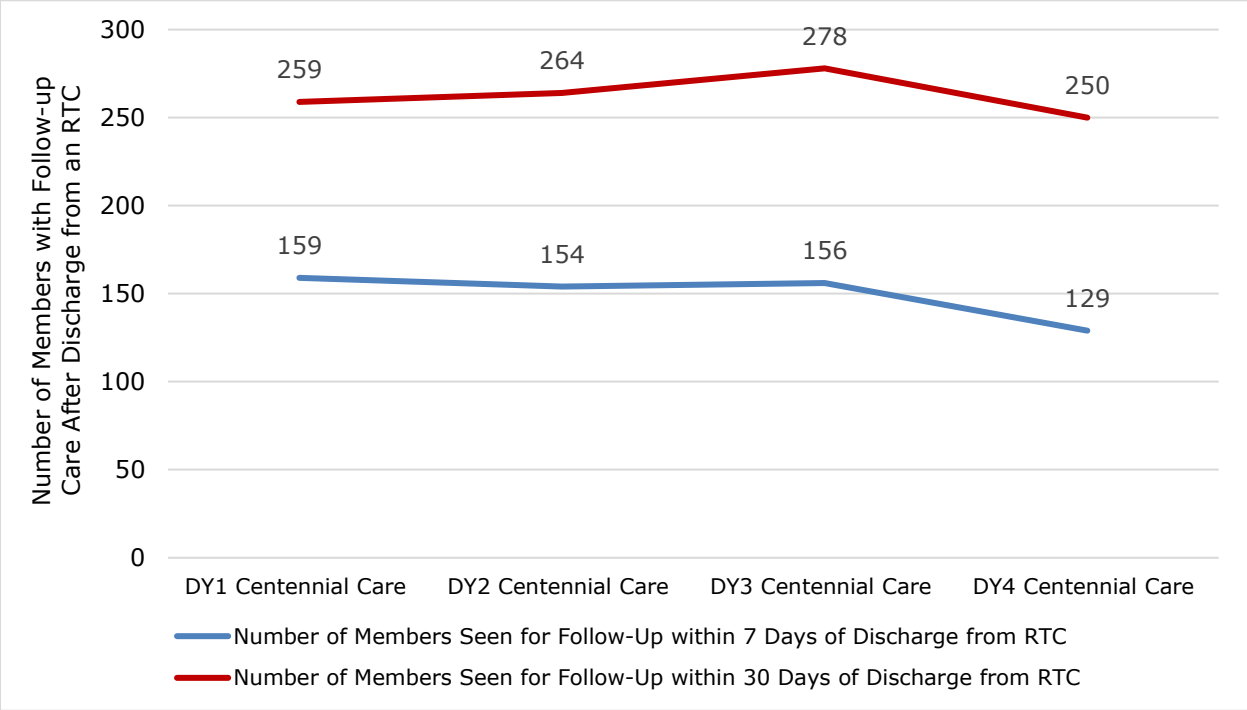
Exhibit 14.a – Percentage of Centennial Care Members Seen for a Follow-up with 7 and 30 Days after Discharge from an RTC[22]



	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	25.7%	44.0%
DY3 Centennial Care	24.1%	43.0%
DY4 Centennial Care	21.8%	42.3%

[22] Source: MCO reports for 2014 – 2017 (HSD/MAD 5). Note that BCBS data for DY2 was updated to reflect most current information since the Interim Report; therefore, the DY2 aggregate rates displayed in the exhibit have been updated. 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.

Exhibit 14.b – Number of Centennial Care Members Seen for a Follow-up with 7 and 30 Days after Discharge from an RTC[23]



[23] Source: MCO reports for 2014 – 2017 (HSD/MAD 5). Note that BCBS data for DY2 was updated to reflect most current information since the Interim Report; therefore, the DY2 aggregate rates displayed in the exhibit have been updated. 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.

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

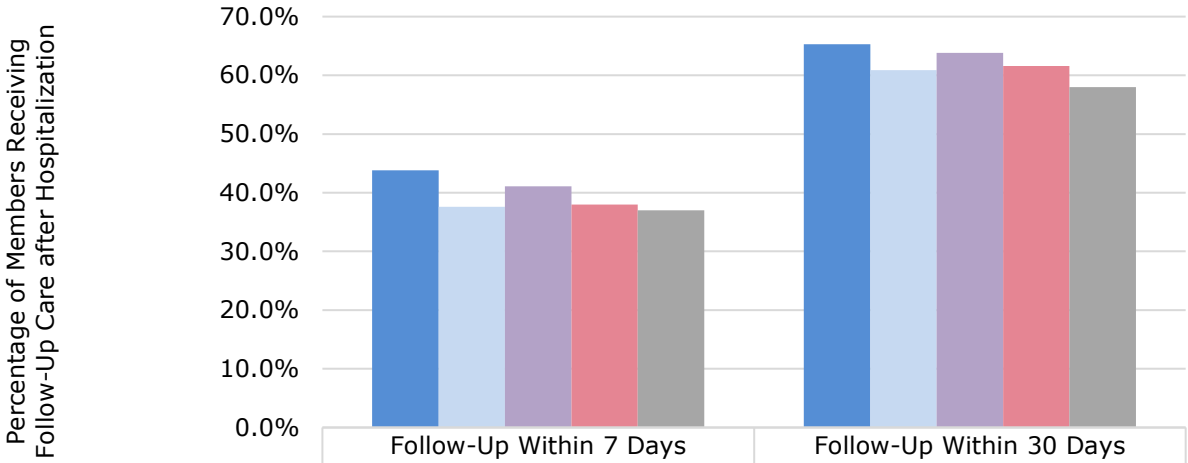
Exhibit 15.a and 15.b presents results for the percentage and number of Centennial Care members discharged after a hospitalization for mental illness and seen for follow-up care within 7 days and 30 days for DY1 through DY4. The 2017 HEDIS Medicaid national average for 7 and 30-day follow-up percentages are also presented.

As illustrated, there was an initial decline in rates of follow-up care within 7 days and 30 days from DY1 to DY2 (-14.2% and -6.9%, respectively), followed by an increase in the percentage of members who received follow-up care after their discharge from DY2 to DY3 (9.5% for 7-day follow-up and 4.8% for 30-day follow-up). However, rates dropped from DY3 to DY4 (-7.6% and -3.5%, respectively). Despite this decrease, the rates for both subcomponents exceeded the 2017 HEDIS Medicaid national average.

Aggregate increases experienced in DY3 and decreases in DY4 were statistically significant at the 95% confidence level.

The decline in the rates of follow-up care within 7 days and 30 days were 13.2% and 5.7% respectively from DY1 to DY4. These decreases were statistically significant at the 95% confidence level.

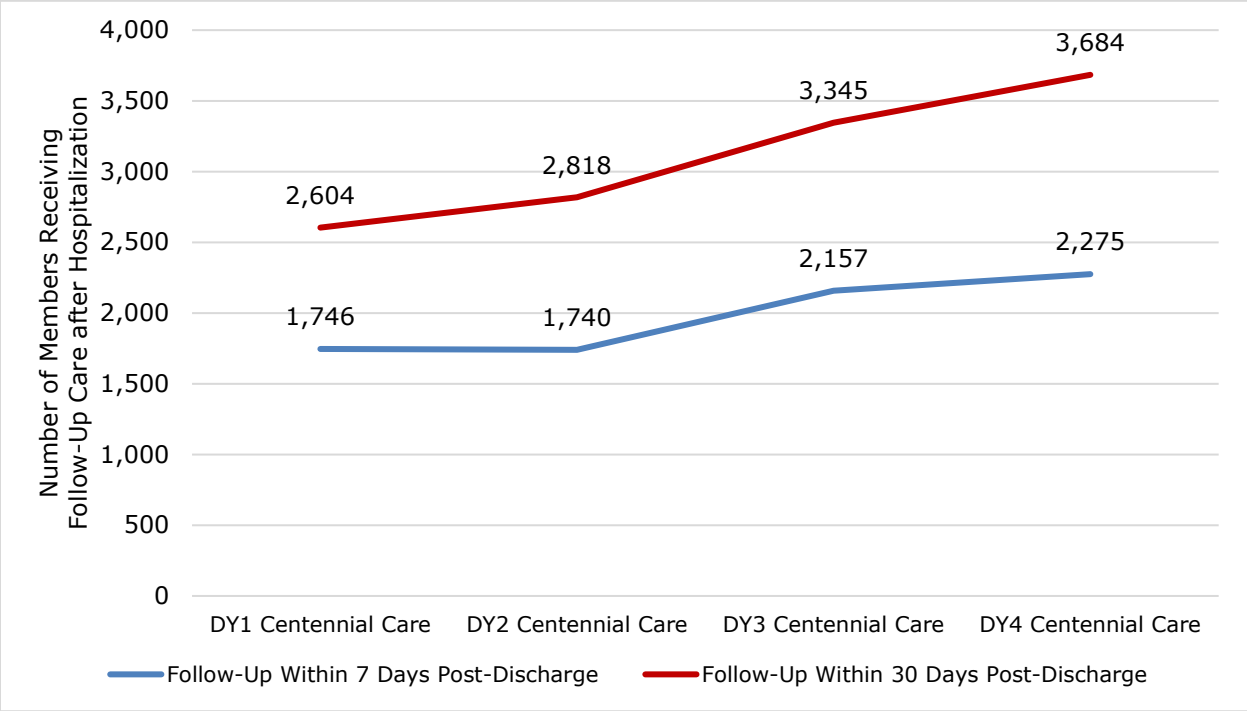
Exhibit 15.a – Percentage of Participants with Follow-up after Hospitalization for Mental Illness[24]



	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%
DY3 Centennial Care	41.1%	63.8%
DY4 Centennial Care	38.0%	61.6%
2017 National Average	37.0%	58.0%

[24] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measure "fuh").
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.

Exhibit 15.b – Number of Participants with Follow-up after Hospitalization for Mental Illness[25]



[25] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measure "fuh"). Note that the DY2 number of members receiving follow-up care did not include supplemental records in the Interim report. Supplemental records have been included in this report.

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.

Measure 16 – Childhood immunization status.

Exhibit 16 presents rates for the 2013 baseline through DY4 and available 2017 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 through DY4[26].

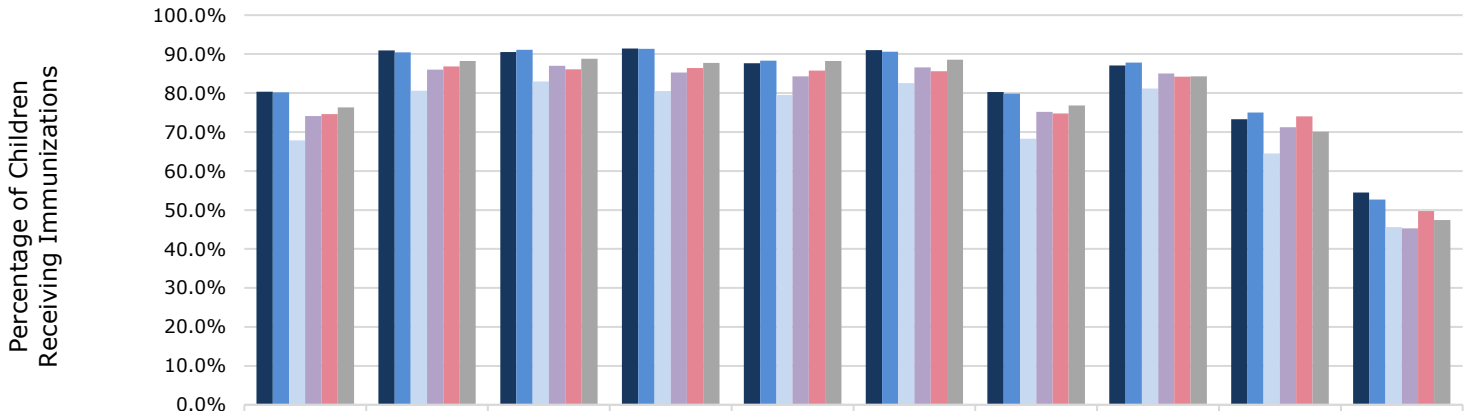
As illustrated, rates of all measures of childhood immunization fluctuated between the baseline and performance years. For example, rates for 10 of the 19 subcomponents increased from the baseline to DY1, although none of the changes were statistically significant at the 95% confidence level. Most MCOs experienced significant declines in immunizations from DY1 to DY2, however, rates for the most part improved in later years of Centennial Care; 18 of 19 subcomponents increased between 2.1% – 13.2% from DY2 to DY3 and rates for 15 subcomponents improved between 0.6% – 8.8% from DY3 to DY4.

The rate of immunizations across 16 subcomponents ultimately declined from the baseline to DY4, while three subcomponents improved.

DY4 rates for three subcomponents exceeded the national averages.

[26] UHC did not participate in Salud! in the 2013 baseline.

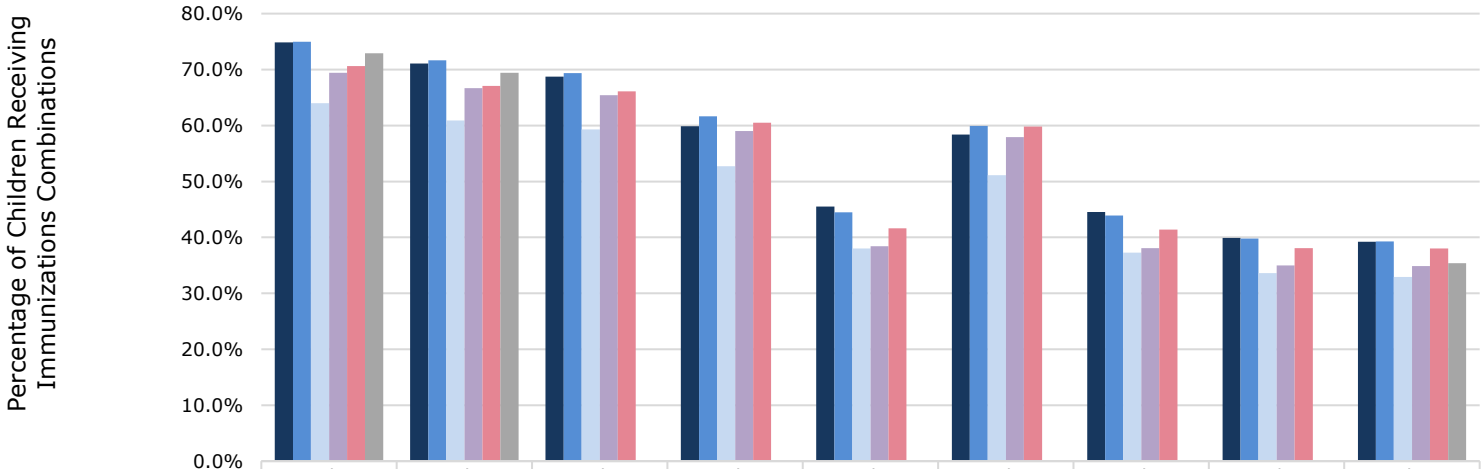
Exhibit 16 – Childhood Immunization Status[27]



	DTaP	IPV	MMR	HiB	Hep B	VZV	PCV	Hep A	Rotavirus	Influenza
2013 Baseline	80.4%	90.9%	90.5%	91.5%	87.6%	91.0%	80.2%	87.1%	73.3%	54.5%
DY1 Centennial Care	80.2%	90.5%	91.1%	91.3%	88.4%	90.6%	79.8%	87.9%	75.0%	52.7%
DY2 Centennial Care	67.9%	80.6%	83.0%	80.5%	79.5%	82.6%	68.3%	81.2%	64.5%	45.6%
DY3 Centennial Care	74.1%	86.0%	87.0%	85.3%	84.3%	86.6%	75.2%	85.0%	71.2%	45.3%
DY4 Centennial Care	74.6%	86.8%	86.1%	86.4%	85.8%	85.6%	74.8%	84.2%	74.0%	49.7%
2017 National Average	76.3%	88.2%	88.8%	87.7%	88.2%	88.6%	76.8%	84.3%	70.1%	47.4%

[27] Source: MCO annual HEDIS reports for 2013-2017 (HEDIS Measure "cis").
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.

Exhibit 16 – Childhood Immunization Status (continued)[28]



	Combo 2	Combo 3	Combo 4	Combo 5	Combo 6	Combo 7	Combo 8	Combo 9	Combo 10
2013 Baseline	74.9%	71.1%	68.7%	59.9%	45.5%	58.4%	44.5%	39.9%	39.2%
DY1 Centennial Care	75.0%	71.7%	69.4%	61.6%	44.5%	59.9%	43.9%	39.8%	39.3%
DY2 Centennial Care	64.0%	60.9%	59.3%	52.7%	38.0%	51.1%	37.3%	33.6%	32.9%
DY3 Centennial Care	69.4%	66.7%	65.4%	59.0%	38.4%	57.9%	38.1%	35.0%	34.9%
DY4 Centennial Care	70.6%	67.1%	66.1%	60.5%	41.6%	59.8%	41.4%	38.1%	38.0%
2017 National Average	72.9%	69.4%							35.4%

[28] 2017 HEDIS Medicaid national averages are not published for Combinations four through nine.

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.

Measure 17 – Immunizations for Adolescents.

Exhibit 17 presents rates for Immunizations for Adolescents in the 2013 baseline through DY4 and the 2017 HEDIS Medicaid national averages. There are multiple subcomponents of immunizations demonstrated within this measure: rates for vaccinations for meningococcal; tetanus, diphtheria, and pertussis (Tdap/Td); Combination 1 (meningococcal, Tdap/Td); Human Papilloma Virus (HPV); and Combination 2 (meningococcal, Tdap/Td, HPV). HPV and Combination 2 were added to the HEDIS measure in DY3, so rates are represented for two of the four performance years.

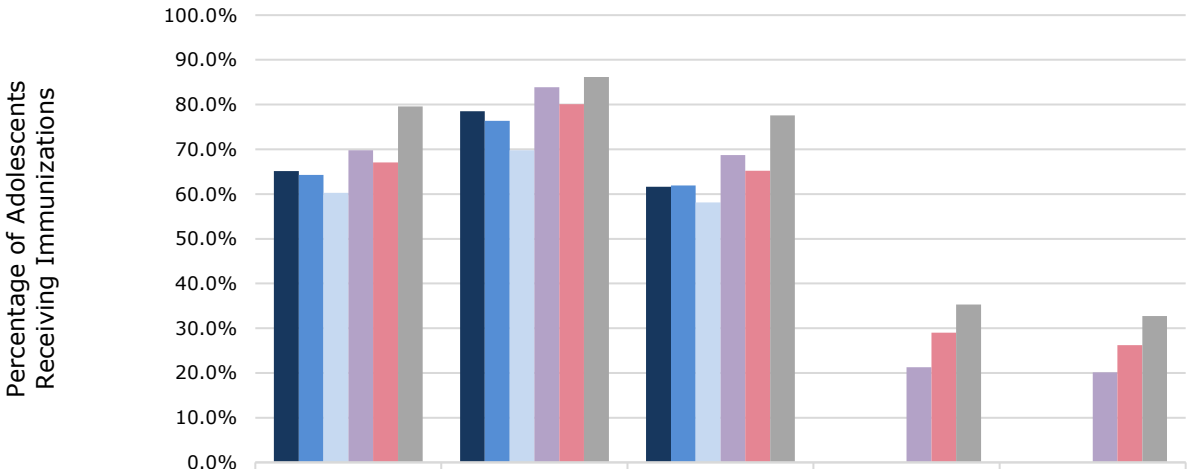
The rate for meningococcal, Tdap/Td, and Combination 1 vaccinations decreased by 3.9%, 4.5%, and 5.0% respectively from DY3 to DY4. The declines for Tdap/Td and Combination 1 were statistically significant at the 95% confidence level. The rate of HPV immunizations and Combination 2 immunizations (Combination 2 includes meningococcal, Tdap/Td, and HPV vaccines) increased 36.0% and 30.3% respectively, which was statistically significant at the 95% confidence level.

Upon reviewing individual MCO performance, PHP experienced relatively consistent performance from the baseline to DY4, while MHC experienced statistically significant increases over the same period. BCBS and UHC did not have reportable rates during the baseline, however they experienced statistically significant increases from DY1 to DY4.

Overall, the rates improved from the baseline to DY4 for all three subcomponents; meningococcal increased by 3.1%, Tdap/Td increased by 2.0%, and Combination 1 increased by 5.9%.

The DY4 rates for all five subcomponents of immunizations were below the 2017 national average rates.

Exhibit 17 – Immunizations for Adolescents[29]



	Meningococcal	Tdap/Td	Combination 1	HPV	Combination 2
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%		
DY3 Centennial Care	69.8%	83.9%	68.7%	21.3%	20.1%
DY4 Centennial Care	67.1%	80.1%	65.2%	29.0%	26.2%
2017 National Average	79.6%	86.2%	77.6%	35.3%	32.7%

[29] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measure "ima"). BCBS reported using the administrative method of data collection for DY1 and DY2, while the other plans used the hybrid method. Therefore, BCBS was excluded from the aggregate results in DY1 and DY2. 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.
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.

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

Exhibit 18 presents rates for six or more Well-Child Visits in the First 15 Months of Life[30] for the 2013 baseline through DY4 and the 2017 HEDIS Medicaid national average[31]. 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 (see footnote beneath exhibit for more details).

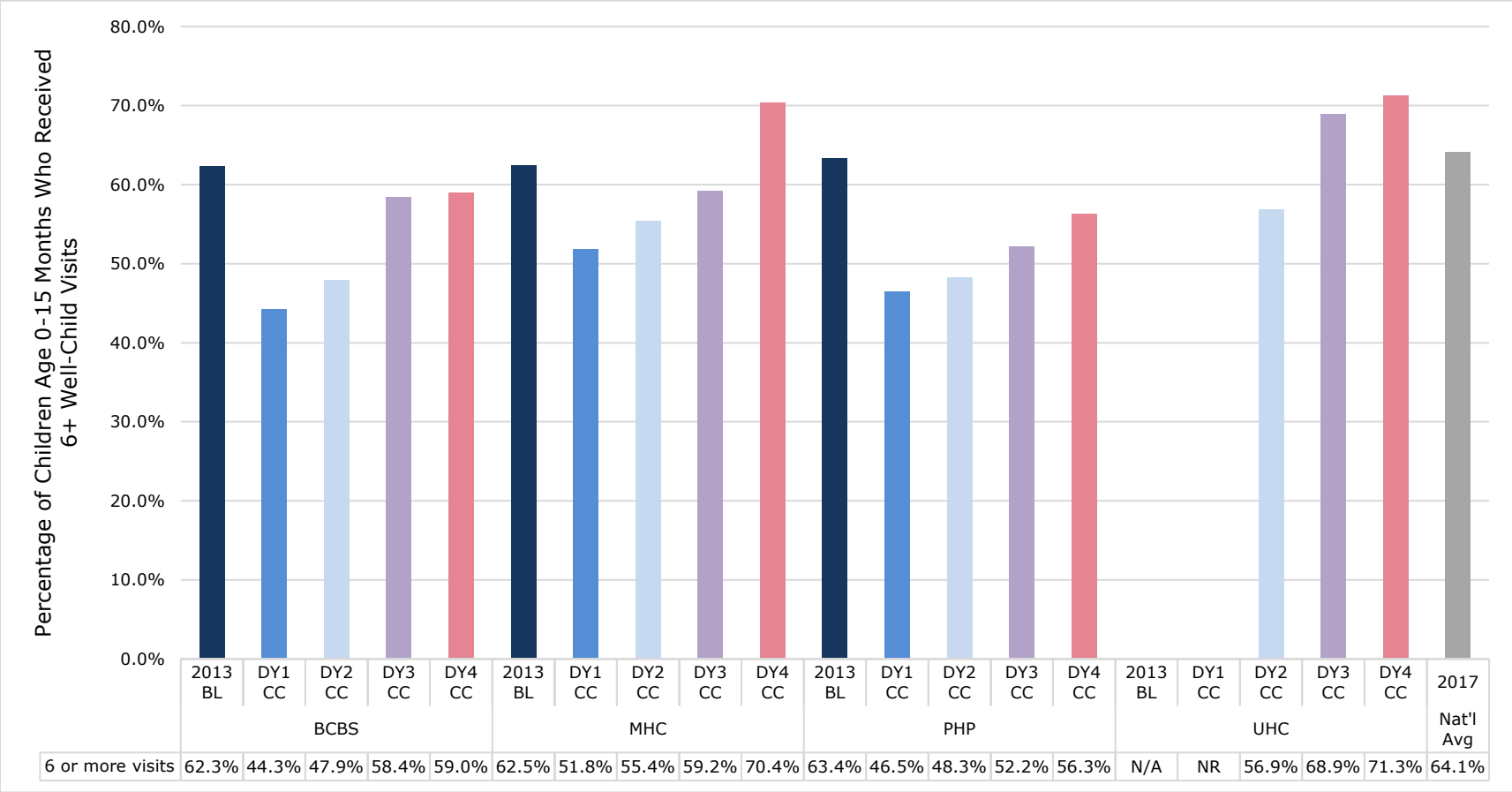
The three Centennial Care MCOs (MHC, PHP, and BCBS) that collected data consistently from the baseline through DY4 each experienced statistically significant declines in rates from the baseline to DY1. Yet, all three plans experienced year-over-year increases in subsequent years. Overall, PHP and BCBS reported declines from the baseline to DY4 of 11.2% and 5.3% respectively, while MHC experienced a statistically significant increase in its visit rate by 12.6% from the baseline to DY4. UHC experienced a statistically significant increase of 20.9% from DY2 to DY3 and a modest increase of 3.5% from DY3 to DY4.

Rates for two of the four MCOs exceeded the 2017 HEDIS Medicaid national average.

[30] HEDIS measure includes seven subcomponents capturing the frequency of visits, from zero visits to six or more visits, received by children 15 months and younger during the measurement year. While data collected by the MCOs included those seven components, focus of this measure was on the highest volume subcomponent, six or more visits.

[31] NCQA Quality Compass National Average for all lines of business provided by HSD/MAD.

Exhibit 18 – Well-Child Visits in First 15 Months of Life (Plan-by-Plan Rates)[32]



	2013 BL	DY1 CC	DY2 CC	DY3 CC	DY4 CC	2013 BL	DY1 CC	DY2 CC	DY3 CC	DY4 CC	2013 BL	DY1 CC	DY2 CC	DY3 CC	DY4 CC	2013 BL	DY1 CC	DY2 CC	DY3 CC	DY4 CC	2017 Nat'l Avg
	BCBS					MHC					PHP					UHC					
6 or more visits	62.3%	44.3%	47.9%	58.4%	59.0%	62.5%	51.8%	55.4%	59.2%	70.4%	63.4%	46.5%	48.3%	52.2%	56.3%	N/A	NR	56.9%	68.9%	71.3%	64.1%

[32] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measure "w15"). UHC did not participate in Salud! in the 2013 baseline and reported "Not Reportable" (NR) in DY1 and used a hybrid methodology DY2 through DY4. All reporting plans used a hybrid methodology in the baseline; PHP and BCBS reported rates using an administrative methodology, while MHC reported rates using a hybrid methodology DY1 through DY4. An aggregate rate was not calculated due to the different reporting methodologies.
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.

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

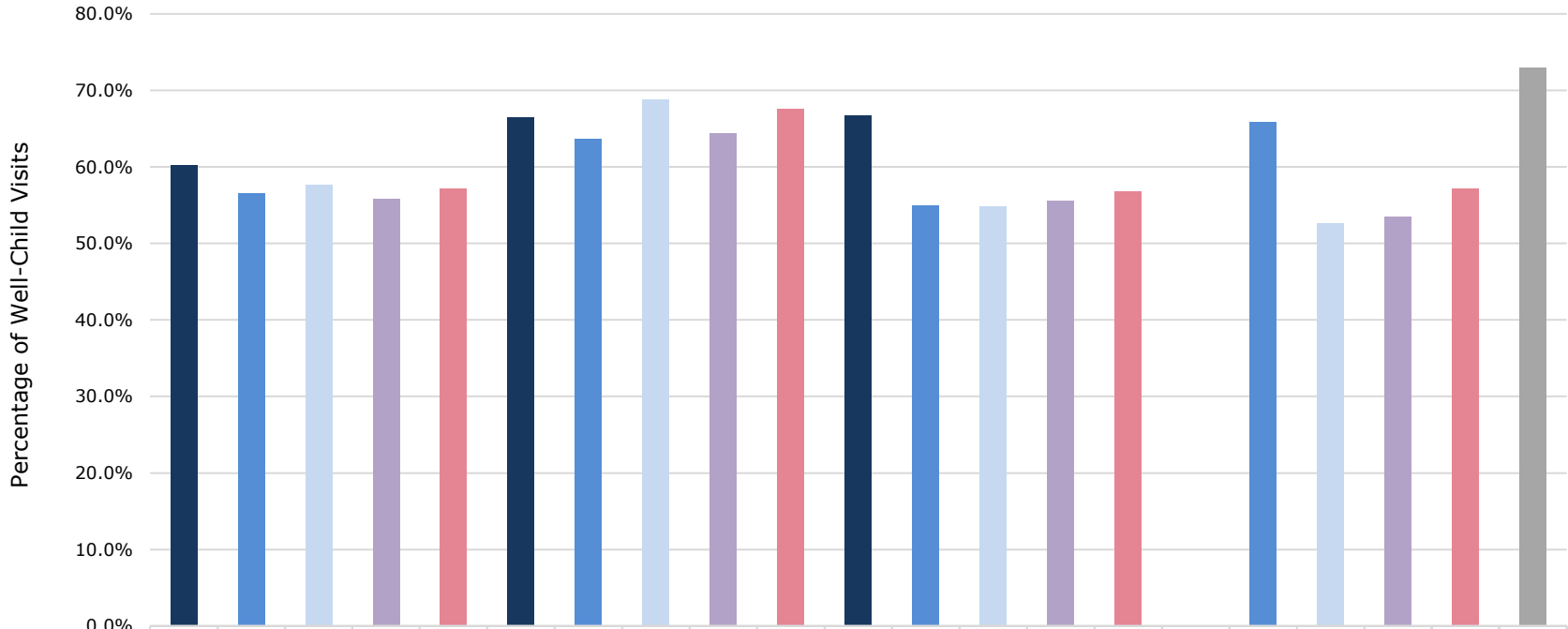
Exhibit 19 presents rates for Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life for the 2013 baseline through DY4 and the 2017 HEDIS Medicaid national average. The evaluation considered rates for the four MCOs on an individual basis; because of the varied methodologies plans used to report rates, an aggregate rate was not assessed (see footnote beneath exhibit for more details).

All MCOs experienced increases in rates ranging from 2.2% to 6.8% from DY3 to DY4. UHC experienced the largest increase at 6.8%, followed by MHC (5.0%), BCBS (2.5%), and PHP (2.2%), though MHC had the highest DY4 performance results at 67.6% for the measure. Increases for PHP and BCBS were statistically significant at the 95% confidence level.

MHC experienced the only increase (1.7%) from the baseline to DY4, while PHP and BCBS experienced declines of 14.8% and 4.9% respectively. UHC did not report in the baseline period, but overall experience declined 13.3% from DY1 to DY4. PHP's and UHC's declines were statistically significant at the 95% confidence level.

All MCOs performance was below the 2017 HEDIS Medicaid national average.

Exhibit 19 – Well-Child Visits in Third, Fourth, Fifth and Sixth Years of Life (Plan-by-Plan Rates)[33]



	BCBS					MHC					PHP					UHC					2017 Nat'l Avg.
	2013 Baseline	DY1 CC	DY2 CC	DY3 CC	DY4 CC	2013 Baseline	DY1 CC	DY2 CC	DY3 CC	DY4 CC	2013 Baseline	DY1 CC	DY2 CC	DY3 CC	DY4 CC	2013 Baseline	DY1 CC	DY2 CC	DY3 CC	DY4 CC	
Well-Child Visits	60.2%	56.6%	57.6%	55.8%	57.2%	66.5%	63.6%	68.8%	64.4%	67.6%	66.7%	54.9%	54.8%	55.6%	56.8%	N/A	65.9%	52.6%	53.5%	57.2%	73.0%

[33] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measure "w34"). UHC did not participate in Salud! in the 2013 baseline. PHP and BCBS reported rates under the Administrative methodology DY1-DY4, while MHC report rates under the Hybrid methodology DY1-DY4. UHC reported under the Hybrid methodology DY2-DY4. An aggregate rate was not calculated due to the different reporting methodologies.
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.

Measure 20 – Adolescent well care visits.

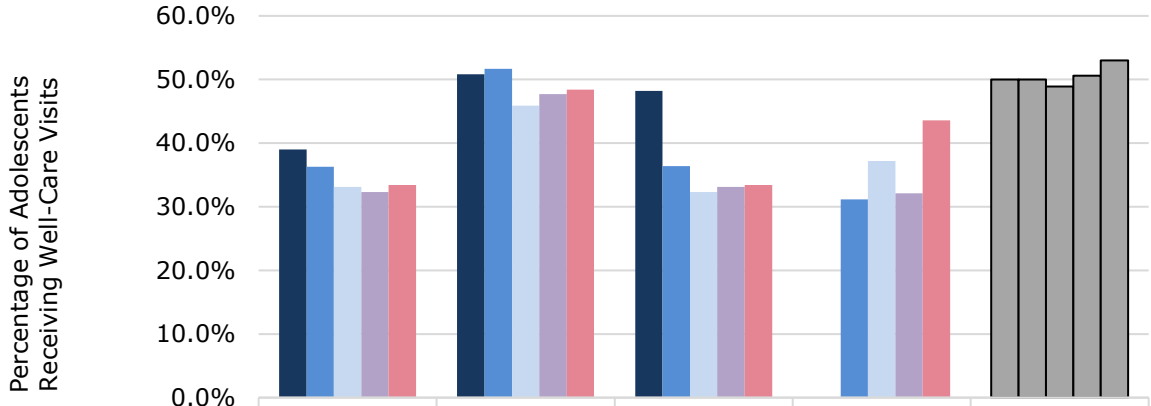
Exhibit 20 presents rates for adolescents receiving at least one well care visit with a primary care or OB/GYN practitioner during the measurement year for the 2013 baseline through DY4 and the 2017 HEDIS Medicaid national average. The evaluation considered rates for the four MCOs on an individual basis; because of the varied methodologies plans used to report rates, an aggregate rate was not assessed (see footnote beneath exhibit for more details).

The three plans that reported in the baseline year experienced an overall decline in rates from the baseline to DY4. PHP showed the largest overall decrease after experiencing declines in the early years of the program (-24.5% from the baseline to DY1, -11.3% from DY1 to DY2) and slight increases in DY3 and DY4 (2.5% improvement from DY2 to DY3 and 1.1% increase from DY3 to DY4). This resulted in an overall decline of 30.6% from the baseline to DY4. BCBS demonstrated similar performance experiencing annual declines of 6.8% (baseline to DY1), 8.9% (DY1 to DY2), and 2.4% (DY2 to DY3). BCBS did experience a 3.4% improvement from DY3 to DY4 — overall resulting in a 14.4% decline from the baseline to DY4. The majority of changes experienced by PHP and BCBS were statistically significant at the 95% confidence level.

MHC showed a smaller decline (-4.6%) than the other MCOs when comparing the baseline to DY4 and it was not statistically significant at the 95% confidence level. The plan demonstrated incremental improvements in three of the four comparison years, including a 1.7% increase from the baseline to DY1, a 3.8% improvement from DY2 to DY3, and a 1.5% increase from DY3 to DY4; the overall 4.6% decline from the baseline to DY4 was driven by an 11.1% decline from DY1 to DY2. UHC did not report in the baseline, but experienced a 19.5% increase from DY1 to DY2, a 13.7% decline from DY2 to DY3, and a statistically significant increase of 35.6% from DY3 to DY4. This resulted in an overall statistically significant increase of 39.8% from DY1 to DY4 for UHC.

MCO experience remained below HEDIS Medicaid national averages in each year of Centennial Care.

Exhibit 20 – Adolescent Well Care Visits[34]



	BCBS	MHC	PHP	UHC	2017 National Average
2013 Baseline	39.0%	50.8%	48.2%	N/A	50.0%
DY1 Centennial Care	36.3%	51.7%	36.4%	31.1%	50.0%
DY2 Centennial Care	33.1%	45.9%	32.3%	37.2%	48.9%
DY3 Centennial Care	32.3%	47.7%	33.1%	32.1%	50.6%
DY4 Centennial Care	33.4%	48.4%	33.4%	43.6%	53.0%

[34] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measure "awc"). UHC did not participate in Salud! in the 2013 baseline. PHP reported rates under the Administrative methodology in DY1 and DY2, BCBS reported under the Administrative methodology in all years, while MHC and UHC reported under the Hybrid methodology. An aggregate rate was not calculated due to the different reporting methodologies.
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.

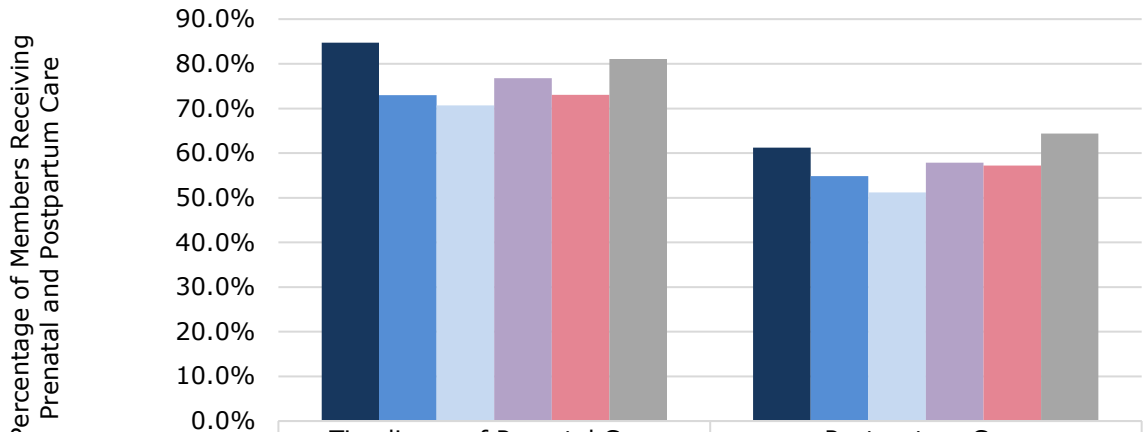
Measure 21 – Prenatal and postpartum care.

Exhibit 21 presents rates for the timeliness of prenatal care and completion of postpartum care for the 2013 baseline through DY4 and the 2017 HEDIS Medicaid national averages.

As illustrated, the rates of prenatal and postpartum declined year-over-year for three of the four comparison years. There was a statistically significant increase in care received from DY2 to DY3; however, there was a decrease of 4.8% for prenatal care and 1.1% for postpartum care from DY3 to DY4. Overall both prenatal care and postpartum care experienced decreases of 13.8% and 6.6% respectively from the baseline to DY4. Both decreases were statistically significant at the 95% confidence level.

The DY4 rates were below the 2017 HEDIS Medicaid national averages for both subcomponents.

Exhibit 21 – Prenatal and Postpartum Care[35]



	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%
DY3 Centennial Care	76.8%	57.8%
DY4 Centennial Care	73.1%	57.2%
2017 National Average	81.1%	64.4%

[35] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measure "ppc").
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.

Measure 22 – Frequency of ongoing prenatal care.

Exhibit 22 presents rates for the 2013 baseline through DY3 and the 2016 HEDIS Medicaid national averages[36] for the Frequency of Ongoing Prenatal Care measure. This measure parses the number of expected prenatal care visits into a distribution, represented by five 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.

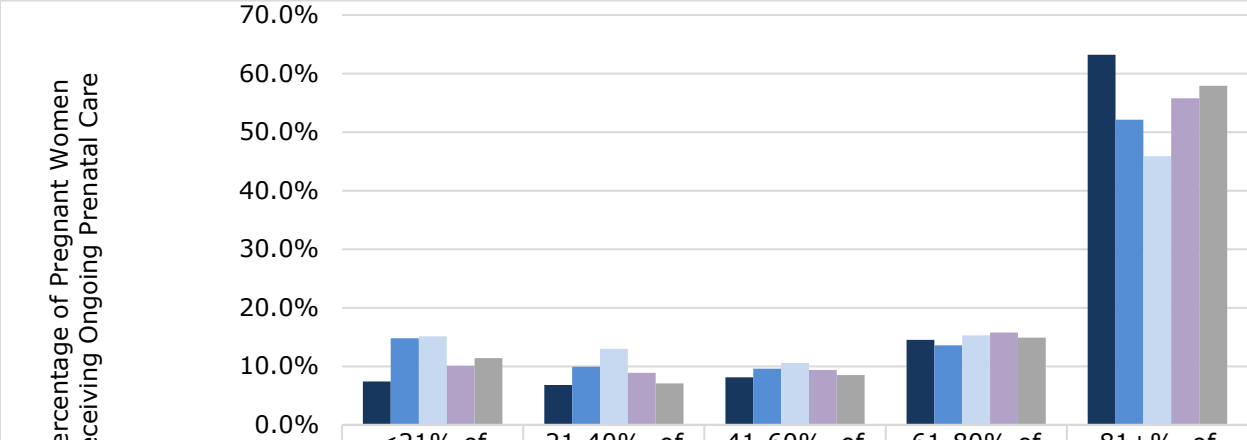
During the first two years of Centennial Care, the distribution of deliveries receiving less than expected visits (≤21% and 21-40% of expected visits) increased while subcomponents with higher compliance decreased. Rates for deliveries that received more frequent visits improved from DY2 to DY3, while subcomponents reflecting fewer prenatal visits declined, signaling better compliance with guidelines. There was a 21.5% improvement in the ≥81% of expected visits subcomponent, a 33.3% decline in deliveries that received <21% expected visits, and a 31.2% decline in deliveries that received 21–40% of expected visits, all of which were statistically significant at the 95% confidence level.

However, when comparing Centennial Care experience from the baseline and DY3, the compliance with recommended guidelines for prenatal visits declined. The percentage of deliveries that received less than 21% of expected visits increased 36.6%, the percentage of deliveries that received 21 – 40% expected visits increased 30.4%, and the percentage of deliveries that received over 81% of expected prenatal visits decreased 11.7%, all of which were statistically significant. Two subcomponents experienced increase in rates but were not statistically significant: deliveries receiving between 41 – 60% (16.4%), and deliveries receiving between 61 – 80% expected visits (9.0%).

The aggregate DY3 results are just below the 2016 HEDIS Medicaid national averages. The total distribution for the top two visit subcomponents (81+% of expected visits and 61-80% of expected visits) was 71.6% for Centennial Care, compared to 72.8% for the 2016 HEDIS Medicaid national average. Centennial Care also achieved a lower rate than the 2016 HEDIS Medicaid national average for the lowest distribution subcomponent (<21% of expected visits), which is a positive outcome.

[36] NCQA retired the measurement of Frequency of Prenatal Care in 2016 as it was redundant, yet less stringent than the Timeliness of Prenatal and Postpartum Care measure, reflected in Measure 21. The latter measure assesses both receipt of visits and whether visits occurred at recommended intervals.

Exhibit 22 – Frequency of Ongoing Prenatal Care[37]



	<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%
DY3 Centennial Care	10.1%	8.9%	9.4%	15.8%	55.8%
2016 National Average	11.4%	7.1%	8.5%	14.9%	57.9%

[37] Source: MCO annual HEDIS reports for 2013 – 2016 (HEDIS Measure "fpc").
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.

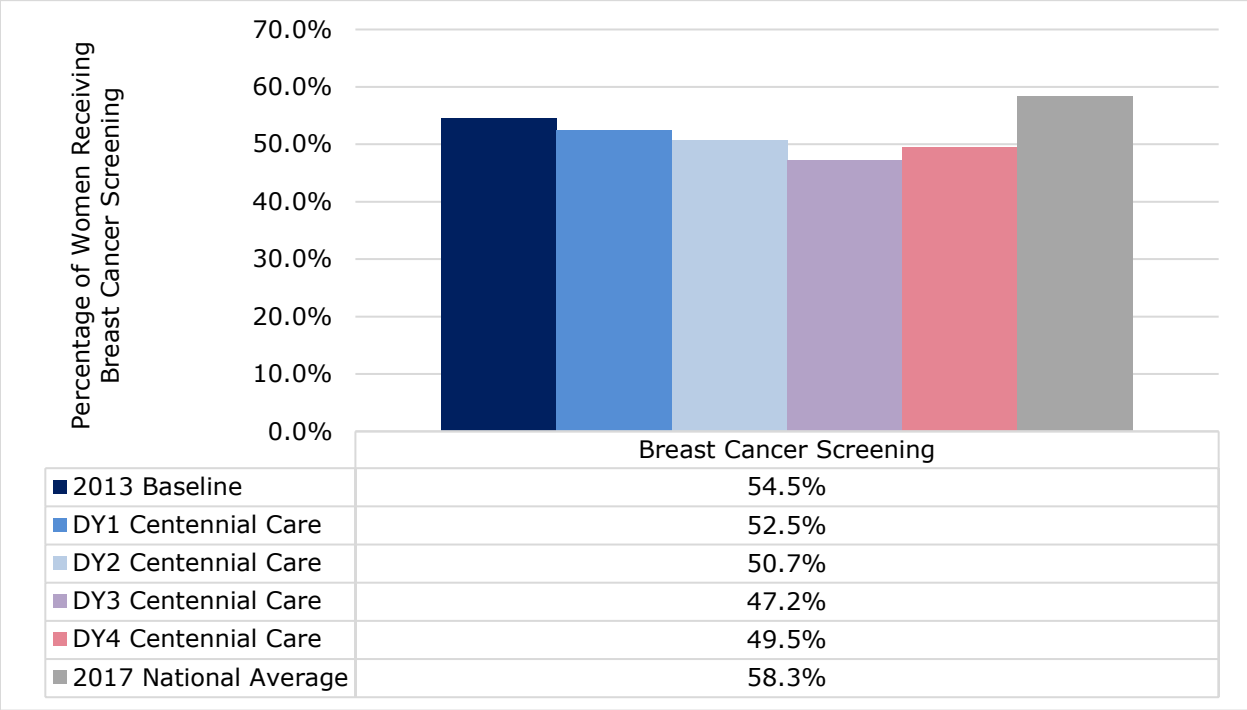
Measure 23 – Breast cancer screening for women.

Exhibits 23.a and 23.b present the percentage and number of women who receive breast cancer screenings for the 2013 baseline through DY4 and the 2017 HEDIS Medicaid national average. As illustrated, there was a statistically significant increase of 4.8% from DY3 to DY4.

Despite this improvement in the final year, there was an overall decline of 9.1% in the rate from the baseline to DY4. This was driven by annual year over year declines experienced from the baseline through DY3 (-3.7% from the baseline to DY1, -3.3% from DY1 to DY2, and -6.9% from DY2 to DY3). Declines from DY1 to DY2 and DY2 to DY3 were statistically significant at the 95% confidence level.

Despite the decline from the baseline to DY4, it is important to note that the number of members receiving screenings has increased from just over 1,500 to nearly 13,000 from the baseline to DY4.

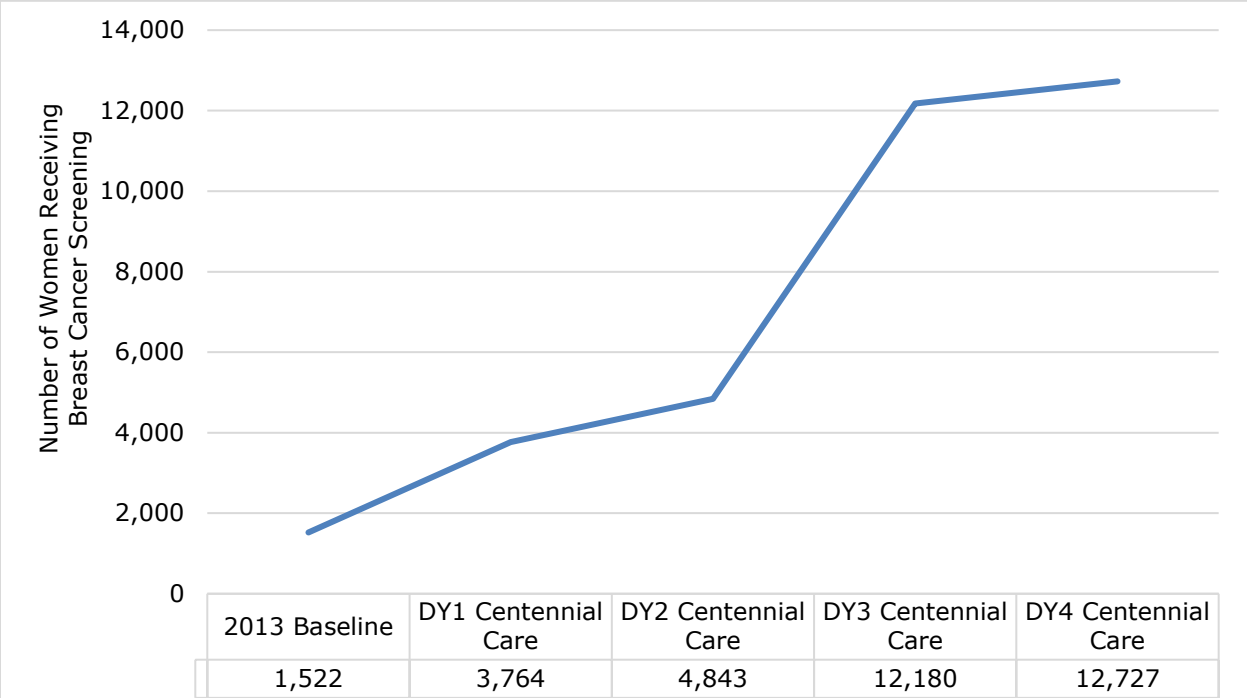
Exhibit 23.a – Breast Cancer Screening Percentage for Women[38]



	Breast Cancer Screening
2013 Baseline	54.5%
DY1 Centennial Care	52.5%
DY2 Centennial Care	50.7%
DY3 Centennial Care	47.2%
DY4 Centennial Care	49.5%
2017 National Average	58.3%

[38] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measure "bcs").
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.

Exhibit 23.b – Number of Women Receiving Breast Cancer Screenings[39]



2013 Baseline	DY1 Centennial Care	DY2 Centennial Care	DY3 Centennial Care	DY4 Centennial Care
1,522	3,764	4,843	12,180	12,727

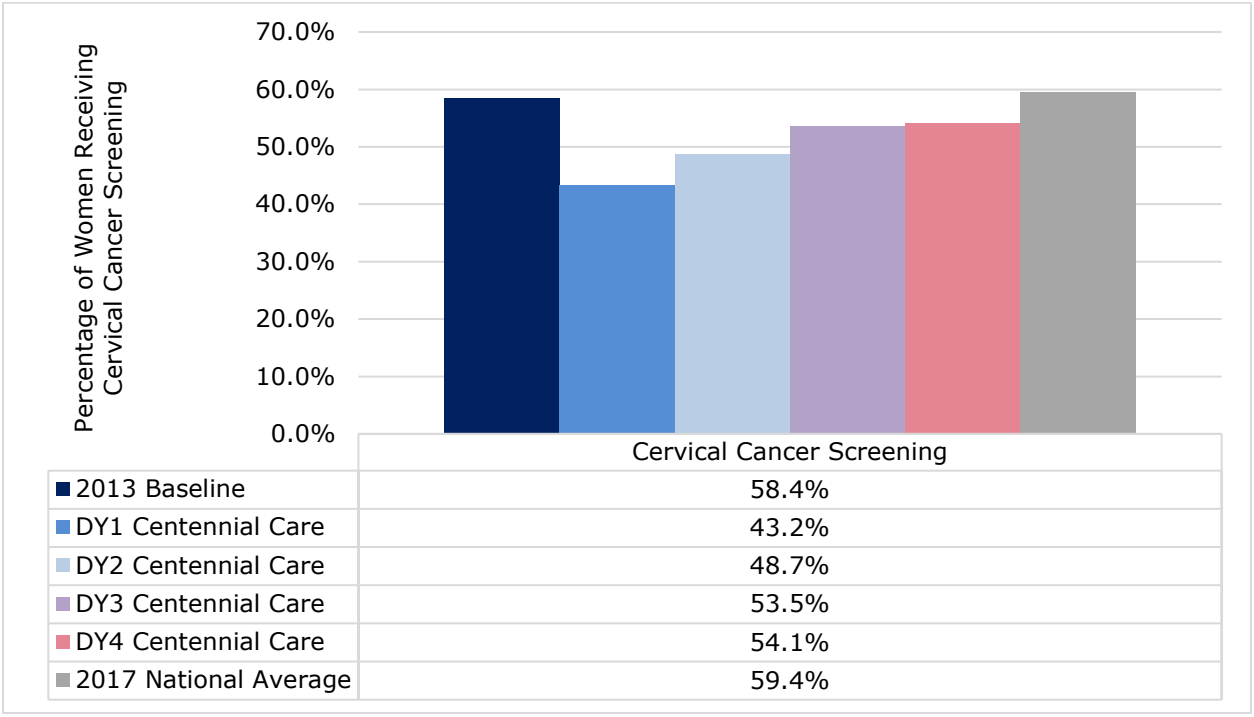
[39] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measure "bcs").

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.

Measure 24 – Cervical cancer screening for women.

Exhibit 24 presents rates for Cervical Cancer Screening for Women for the 2013 baseline through DY4 and the 2017 HEDIS Medicaid national average. After an initial decline of 26.0% from the baseline to DY1, the aggregate performance on completed screenings improved each period thereafter (12.7% from DY1 to DY2, 10.0% from DY2 to DY3, and 1.0% from DY3 to DY4). The rate of screenings experienced a decline of 7.4% from the baseline to DY4, which was a statistically significant change at the 95% confidence level. Performance was relatively consistent across all plans and years.

Exhibit 24 – Cervical Cancer Screening for Women[40]



	Cervical Cancer Screening
2013 Baseline	58.4%
DY1 Centennial Care	43.2%
DY2 Centennial Care	48.7%
DY3 Centennial Care	53.5%
DY4 Centennial Care	54.1%
2017 National Average	59.4%

[40] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measure "css").
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.

Measure 25 – Flu vaccinations for adults.

Exhibit 25 presents results for the 2013 baseline through DY4 and the 2017 CAHPS 5.0H national average for the percentage of flu vaccinations for adults. As illustrated, the percentage of adults indicating they received an immunization increased 6% from DY3 to DY4.

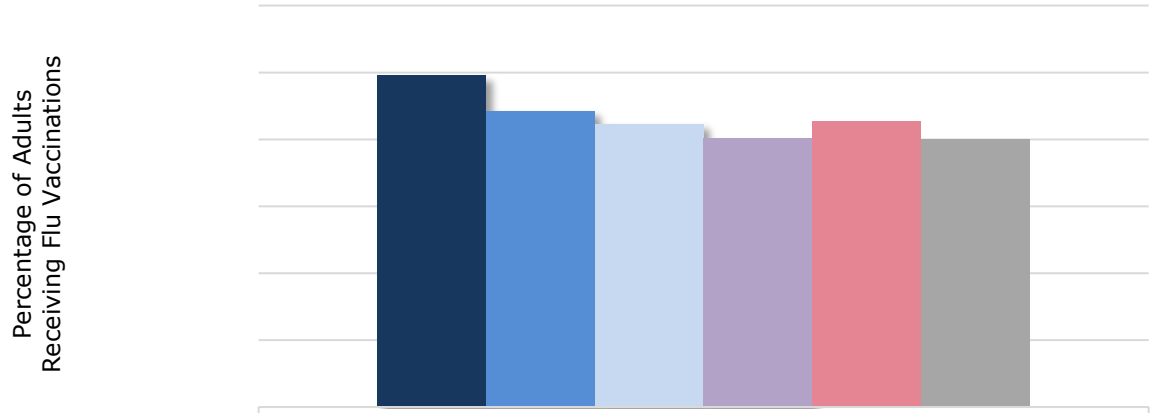
Overall, the percentage of flu vaccinations for adults decreased 14% from the baseline to DY4. When reviewing individual MCO performance from the baseline to DY4, BCBS experienced an increase of 5% while MHC, PHP, and UHC experienced decreases of 5%, 7%, and 36% respectively.

Despite the aggregate decrease from the baseline to DY4, it is important to note that the DY4 results exceeded the national average.

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

The DY4 results exceeded the national average.

Exhibit 25 – Flu Vaccinations for Adults[41]



	Adult
2013 Baseline	50%
DY1 Centennial Care	44%
DY2 Centennial Care	42%
DY3 Centennial Care	40%
DY4 Centennial Care	43%
2017 National Avg	40%

[41] Source: MCO annual CAHPS reports for 2013 – 2017. Note that the data source for this measure was updated from an MMIS-based source to the CAHPS measure for the Final Report. Since members can receive flu vaccinations in many settings that do not generate a claim (such as free vaccinations through employers or community clinics), it was determined the CAHPS measure would more appropriately capture results.
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.

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 through DY4 and the 2017 HEDIS Medicaid national averages for two age cohorts and the total population.

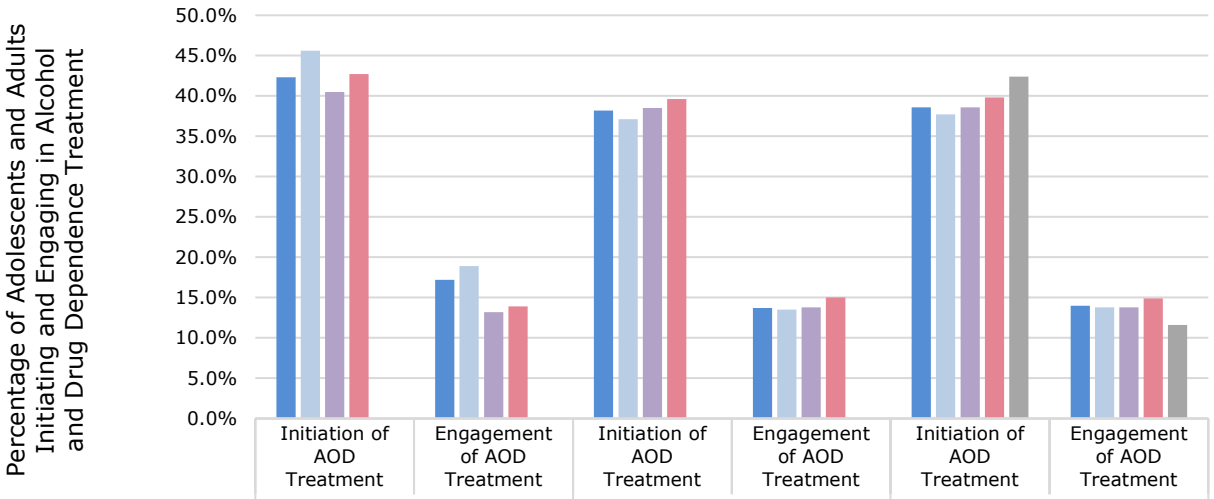
MCO performance for the 13-17 age cohort on both initiation and engagement subcomponents of AOD increased from DY3 to DY4 by 5.4% and 4.6% respectively. The changes were not statistically significant at the 95% confidence level. Rates for the 18+ age cohort experienced increases in the initiation and engagement subcomponents of 2.8% and 8.3%, respectively, from DY3 to DY4. Both increases were statistically significant at the 95% confidence level. The total population increases in initiation and engagement were 2.9% and 8.1% from DY3 to DY4.

The 13-17 age cohort experienced a slight increase in initiation (0.9%) and a statistically significant decrease in engagement (-19.4%) from DY1 to DY4. However, it is important to note that the 13-17 age cohort represents less than 5% of the population targeted for this measure and thus is subject to greater fluctuation.

The 18+ age cohort experienced increases in both initiation (3.6%) and engagement (9.5%) from DY3 to DY4, which were statistically significant at the 95% confidence level. The total population increases in initiation and engagement were 3.1% and 6.7% from DY1 to DY4. These increases were statistically significant at the 95% confidence level.

The DY4 rate for the Engagement of AOD subcomponent exceeded the 2017 HEDIS Medicaid national average.

Exhibit 26.a – Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment[42]



	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%
DY3 Centennial Care	40.5%	13.2%	38.5%	13.8%	38.6%	13.8%
DY4 Centennial Care	42.7%	13.9%	39.6%	15.0%	39.8%	14.9%
2017 National Average					42.4%	11.6%

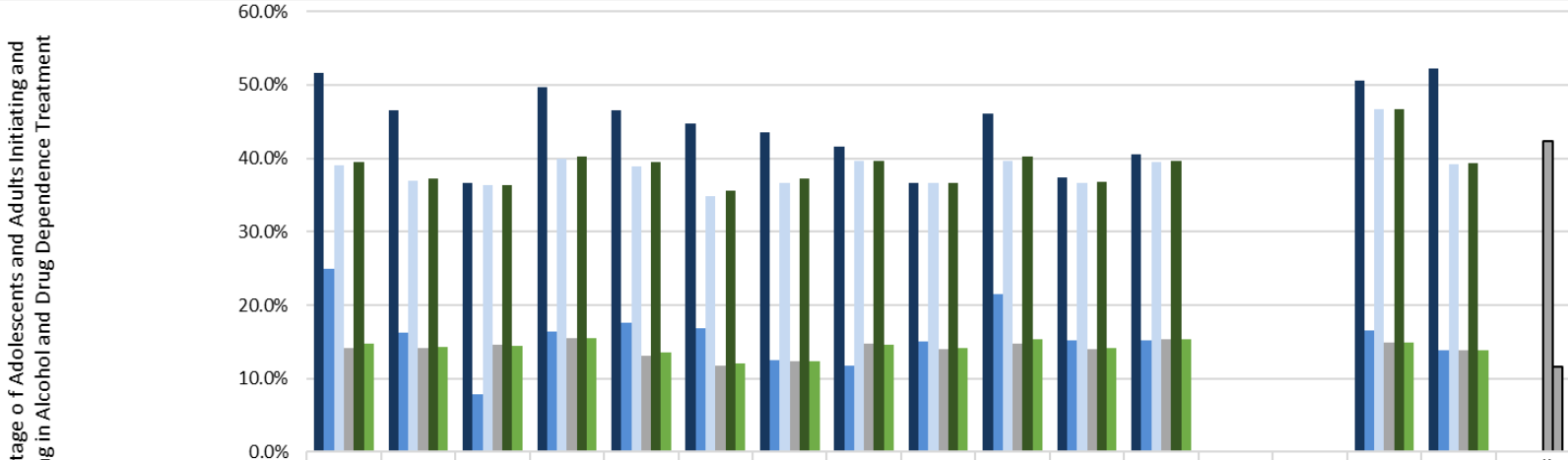
[42] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measure "iet"). UHC reported "Not Reportable" (NR) in DY1 and DY2. In the context of this report, discussions of changes in measure values between periods are based on the percent change (increase/decrease) which is calculated as [Current period measure value] / [Prior period measure value] – 1.

Exhibit 26.b below presents individual MCO performance on the Initiation and Engagement of AOD. PHP experienced an improvement from DY3 to DY4 for five of the six subcomponents (with the exception of engagement in AOD treatment for the 13-17 age cohort), most of which were statistically significant at the 95% confidence level.

MHC experienced improvement in four of the six subcomponents (for initiation and engagement in AOD treatment for the 18+ age cohort and the total population) from DY3 to DY4. This included a 20.2% increase in the 18+ age cohort engaging in treatment which was statistically significant at the 95% confidence level. BCBS also experienced dramatic, statistically significant improvement in most subcomponents from DY3 to DY4. For example, engagement in treatment for the 13-17 age cohort increased 106.7%. UHC experienced declines across five of six subcomponents from DY3 to DY4, but only two of five decreases were statistically significant.

Each MCO's rate for the engagement in AOD subcomponent exceeded the 2017 HEDIS Medicaid national average.

Exhibit 26.b. – Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (Plan by Plan Rates)[43]



	BCBS				MHC				PHP				UHC				
	DY1 CC	DY2 CC	DY3 CC	DY4 CC	DY1 CC	DY2 CC	DY3 CC	DY4 CC	DY1 CC	DY2 CC	DY3 CC	DY4 CC	DY1 CC	DY2 CC	DY3 CC	DY4 CC	Nat'l Avg 2017
13-17 years Initiation of AOD Treatment	51.6%	46.6%	36.7%	49.7%	46.6%	44.8%	43.5%	41.6%	36.6%	46.1%	37.4%	40.6%			50.6%	52.3%	
13-17 years Engagement of AOD Treatment	25.0%	16.2%	7.9%	16.4%	17.6%	16.8%	12.5%	11.8%	15.0%	21.5%	15.2%	15.2%			16.5%	13.8%	
18+ years Initiation of AOD Treatment	39.0%	37.0%	36.3%	40.0%	38.9%	34.9%	36.7%	39.6%	36.7%	39.6%	36.7%	39.5%			46.7%	39.2%	
18+ years Engagement of AOD Treatment	14.2%	14.2%	14.6%	15.5%	13.1%	11.7%	12.3%	14.8%	14.0%	14.7%	14.0%	15.3%			14.9%	13.9%	
Total Initiation of AOD Treatment	39.5%	37.3%	36.3%	40.3%	39.5%	35.6%	37.2%	39.7%	36.7%	40.2%	36.8%	39.6%			46.7%	39.4%	42.4%
Total Engagement of AOD Treatment	14.7%	14.3%	14.4%	15.5%	13.5%	12.0%	12.3%	14.6%	14.1%	15.3%	14.1%	15.3%			14.9%	13.9%	11.6%

[43] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measure "iet"). UHC reported "Not Reportable" (NR) in DY1 and DY2.
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.

Measure 27 – Geographic access measures.

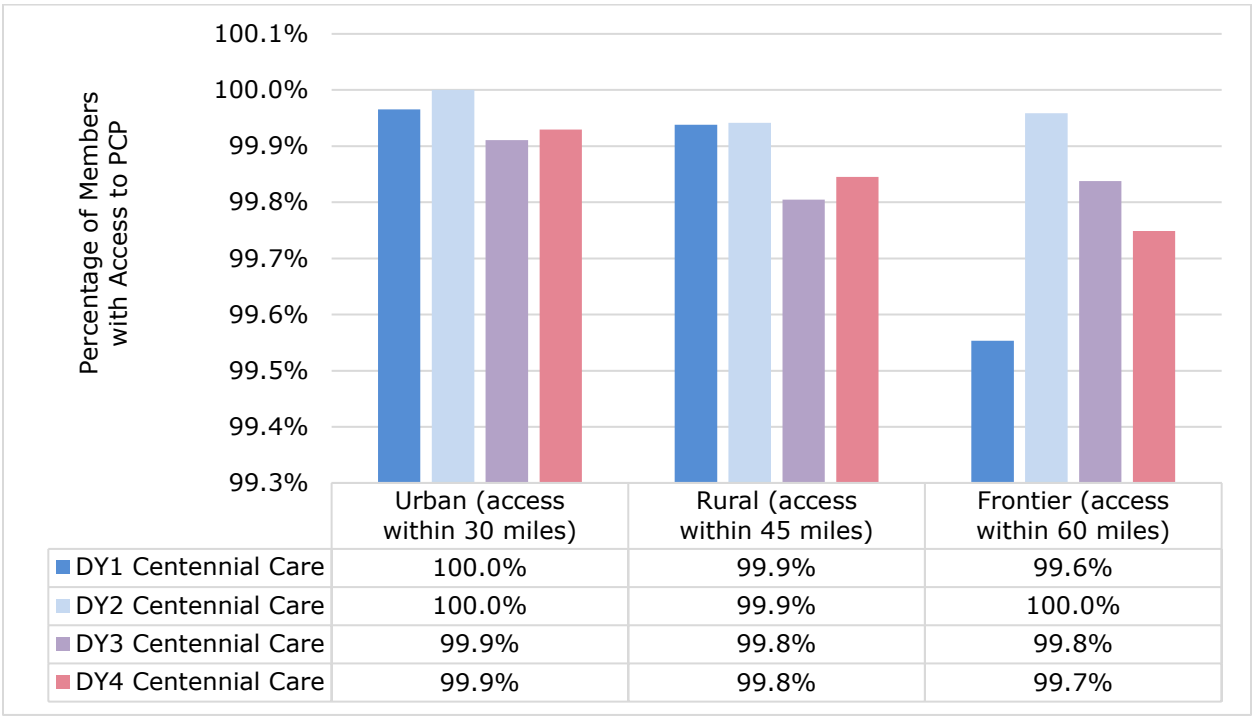
Geographic Access Measures is a general measure developed by HSD/MAD as a way to evaluate access to primary and specialty care for Centennial Care members across the State of New Mexico. Monitoring the networks of providers contracted by HSD/MAD assures its Medicaid beneficiaries are within a reasonable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

HSD/MAD has developed standards for measuring geographic-based access to primary 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 presents results for DY1 through DY4 for the percentage of members with access to PCPs in each county type. As illustrated below, Centennial Care met and exceeded the requirement for accessibility in all county types across all performance years. In addition, each MCO met and exceeded the requirement for accessibility in all county types across all performance years.

Exhibit 27.a – Percentage of Members with Access to PCPs[44]



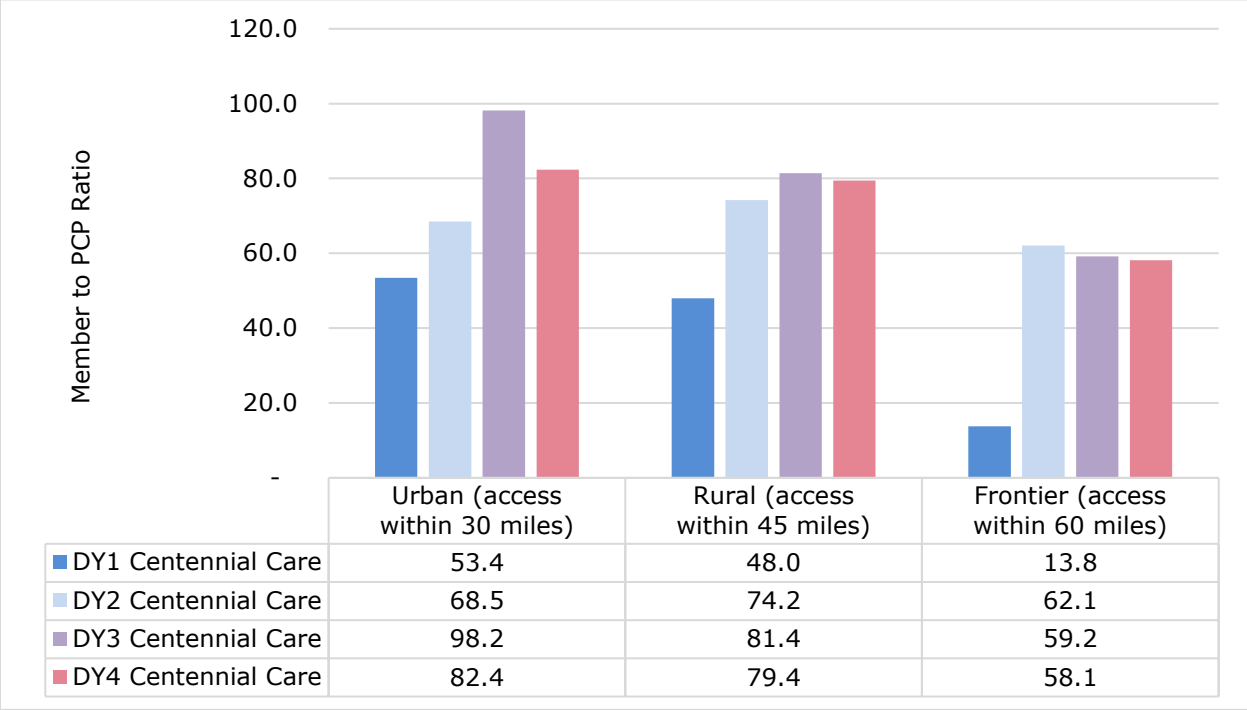
	Urban (access within 30 miles)	Rural (access within 45 miles)	Frontier (access within 60 miles)
DY1 Centennial Care	100.0%	99.9%	99.6%
DY2 Centennial Care	100.0%	99.9%	100.0%
DY3 Centennial Care	99.9%	99.8%	99.8%
DY4 Centennial Care	99.9%	99.8%	99.7%

[44] Source: MCO reports for 2014 – 2017 (HSD/MAD 55).

Exhibit 27.b presents results for DY1 through DY4 of member to PCP ratios by county type. While HSD/MAD 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 generally increased in all county types over the four performance years. These increases are not desired as smaller member to PCP ratios usually indicate greater accessibility. It must be noted that the data and reporting methodology changed over the course of the demonstration, and thus the data points from year to year are not perfectly consistent and results could be skewed by the reporting methodology changes.

Exhibit 27.b – Members to PCP Ratio[45]



	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
DY3 Centennial Care	98.2	81.4	59.2
DY4 Centennial Care	82.4	79.4	58.1

[45] Source: MCO reports for 2014 – 2017 (HSD/MAD 55) as well as supplementary data in HSD3 for 2016 – 2017.

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 reviewed Centennial Care's impact on care coordination through the analysis of four performance measures that assess MCO activities to increase member engagement in the program and understand member health risks. In addition, the design of Research Question 1.C attempts to understand the success of care coordination activities provided to HCBS beneficiaries.

Note that originally there were nine measures to support this research question, however data integrity issues and systematic difficulties among MCOs to collect certain data elements prevented the ability to consistently report over the course of Centennial Care and across certain measures. As a result, five measures have been removed and the remaining measures rely upon DY3 and DY4 data. Although the removal of five of the original nine measures limits the ability to provide conclusive statements on the effectiveness of care coordination activities within the context of Research Question 1.C, there are implied correlations between the effectiveness of care coordination and measures that focus on HCBS and PH/BH benefit integration. See the Evaluation Limitations section for additional information.

Overall through DY4 of the Centennial Care program, process-related care coordination measures generally increased among MCOs as a greater percentage of members assigned to care coordination Level 2 and Level 3 had a CNA to ensure appropriate levels of care continued to be provided.

Performance for the percentage of members who transitioned from a NF into the community improved while the percentage of members who were readmitted to a NF showed a slight increase, which is a decline in performance; despite this slight decline, the overall percentage of members readmitted to NFs throughout Centennial Care has been less than 1%. In addition, the percentage of members that refused care coordination increased, though the overall percentage was relatively low.

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 30 – Number and percentage of Comprehensive Needs Assessments due and completed for care coordination Level 2 members (Number and percentage of participants in care coordination Level 2 that had comprehensive needs assessments scheduled and completed within contract timeframes).

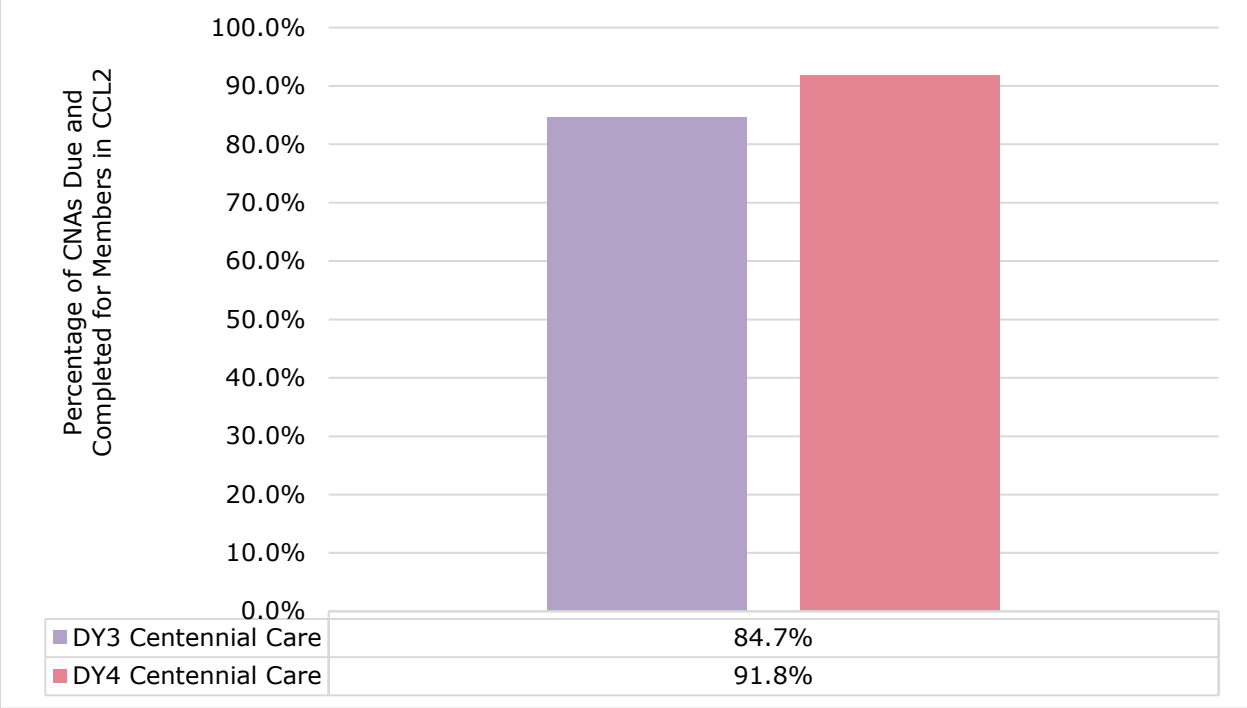
Exhibits 30.a and 30.b below present results for DY3 and DY4 for the percentage and number of members stratified into care coordination Level 2 for whom a CNA was due and completed by their MCO. Note that the underlying source for these data changed during DY3, and therefore only information from DY3 and forward was available for this analysis. In addition, the analysis is on an alternative definition of measure 30 based on the data available.

As the exhibit illustrates, the percentage of CNAs due and completed increased 8.5% from DY3 to DY4. Results for individual MCOs were consistent, ranging from 69% to 92% in DY3 and 76% to 98% in DY4. The aggregate number of CNAs due decreased from DY3 to DY4, which may have contributed to the greater percentage completed, as the number completed in DY3 and DY4 remained close.

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

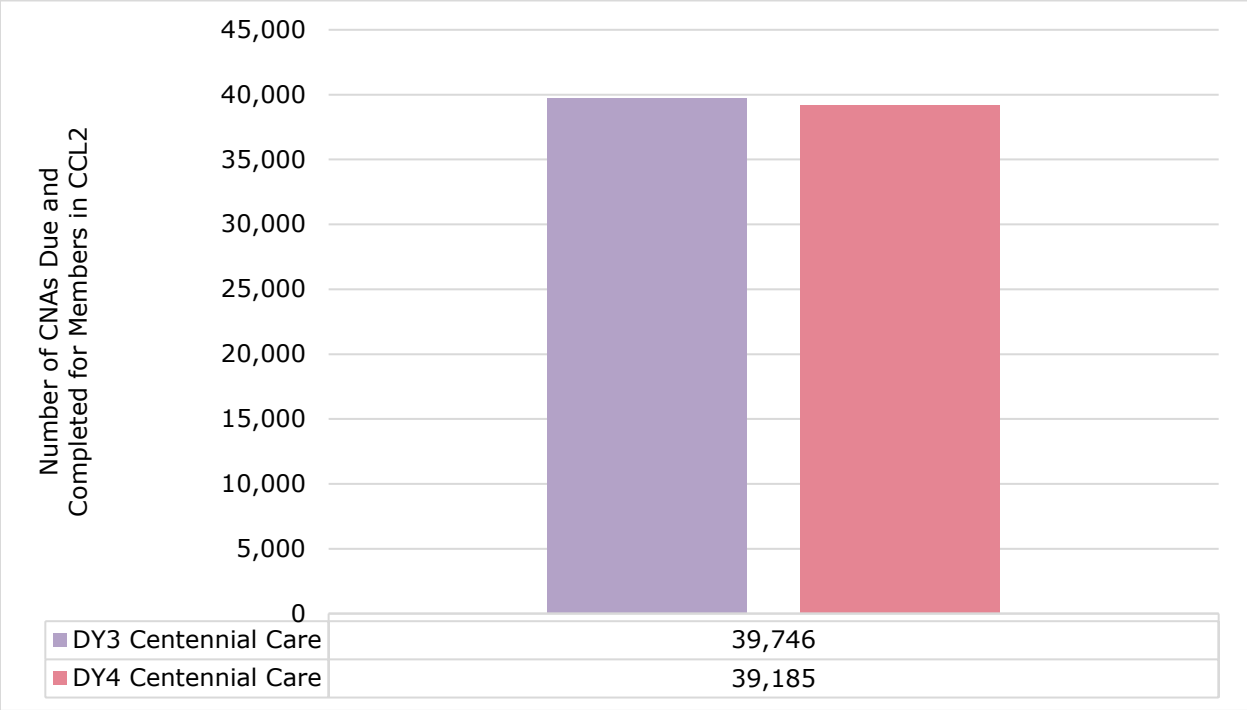
Statistical significance was not calculated for this measure due to the potential underlying differences in reporting methodology utilized by the MCOs.

Exhibit 30.a – Percentage of CNAs Due and Completed for Care Coordination Level 2 Members[46]



[46] Source: MCO reports for 2016 – 2017 (HSD/MAD ad hoc report).
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.

Exhibit 30.b – Number of CNAs Due and Completed for Care Coordination Level 2 Members[47]



[47] Source: MCO reports for 2016 – 2017 (HSD/MAD ad hoc report).
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.

Measure 31 – Number and percentage of Comprehensive Needs Assessments due and completed for care coordination Level 3 members (Number and percentage of participants in care coordination Level 3 that had comprehensive needs assessments scheduled and completed within contract timeframes).

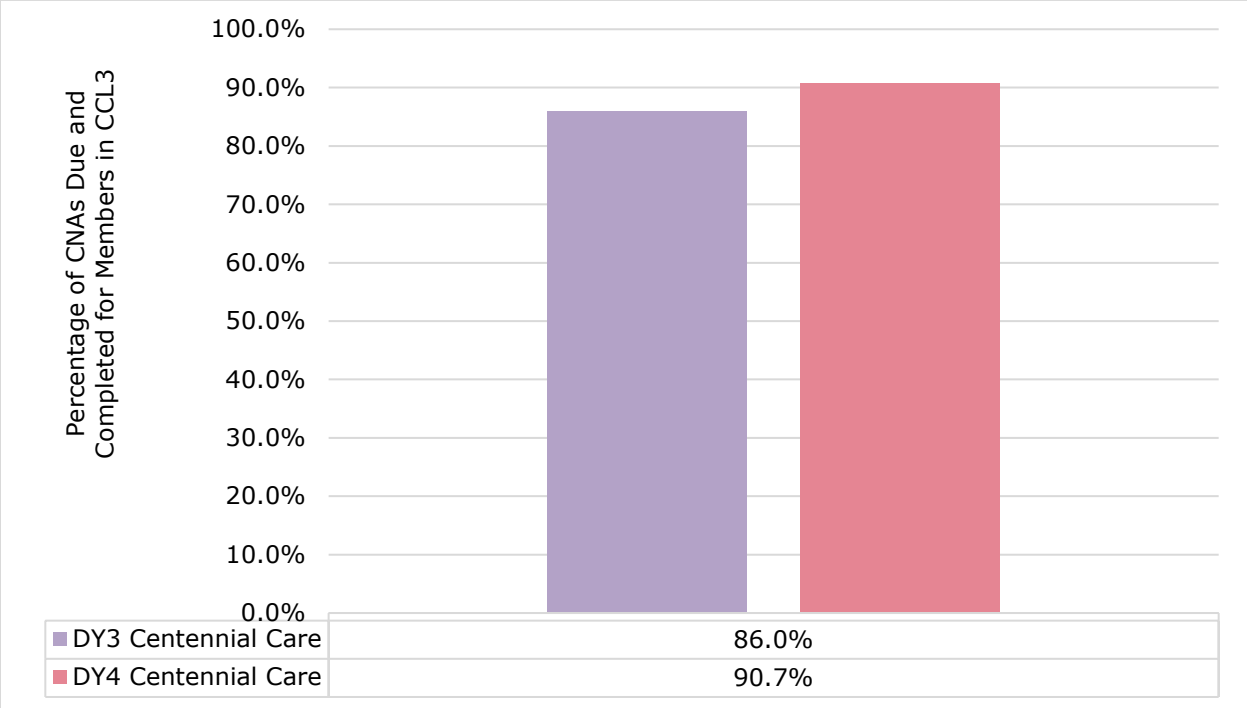
Exhibits 31.a and 31.b below present results for DY3 and DY4 for the percentage and number of members stratified into care coordination Level 3 for whom a CNA was due and completed by their MCO. Note that the underlying data source for this data changed during DY3, and therefore only information from DY3 and forward was available for this analysis. In addition, the analysis is on an alternative definition of measure 31 based on the data available.

As Exhibit 31 illustrates, the percentage of CNAs that were due and completed for Level 3 members increased 5.4% from DY3 to DY4, while the number of CNAs due and completed declined slightly. Individual MCO performance varied for this measure, with UHC reporting the lowest completion rates at 48% in DY3 and 60% in DY4 and BCBS reporting 67% and 76%, respectively. PHP and MHC reported rates over 97% each year.

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

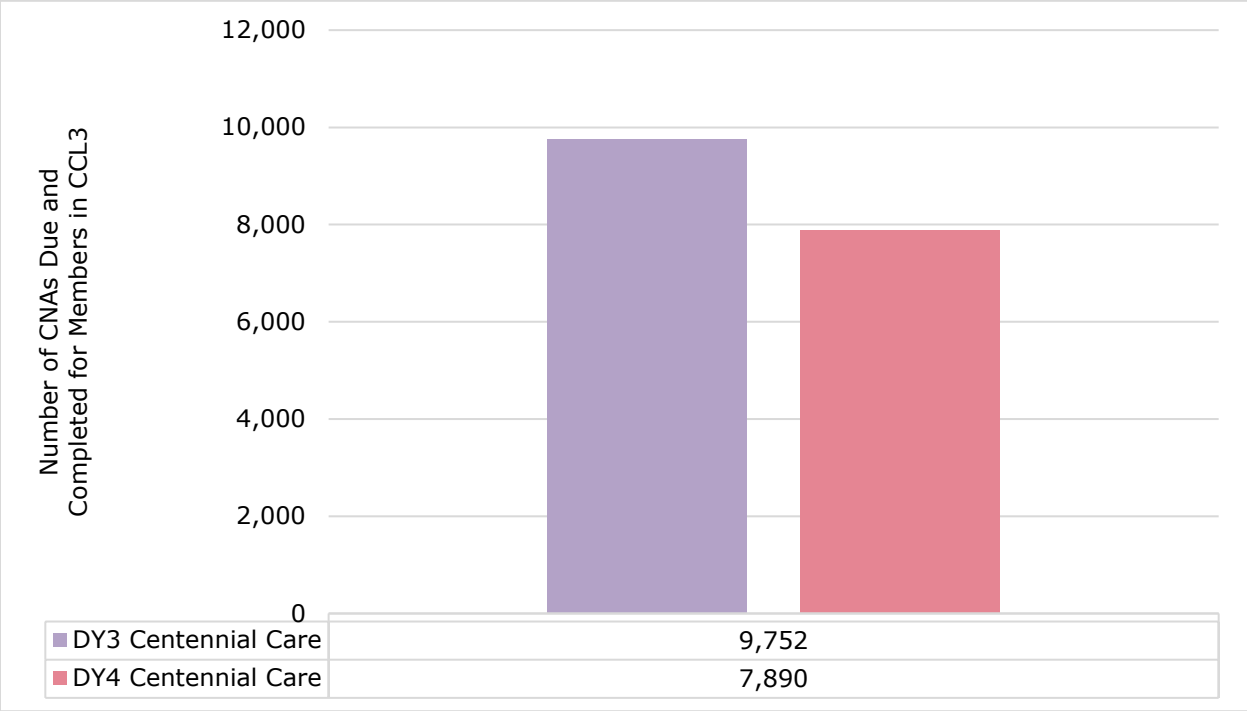
Statistical significance was not calculated for this measure due to the potential underlying differences in reporting methodology utilized by the MCOs.

Exhibit 31.a – Percentage of CNAs Due Completed for Care Coordination Level 3 Members [48]



[48] Source: MCO reports for 2016 – 2017 (HSD/MAD ad hoc report).
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.

Exhibit 31.b – Number of CNAs Due Completed for Care Coordination Level 3 Members[49]



[49] Source: MCO reports for 2016 – 2017 (HSD/MAD ad hoc report).
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.

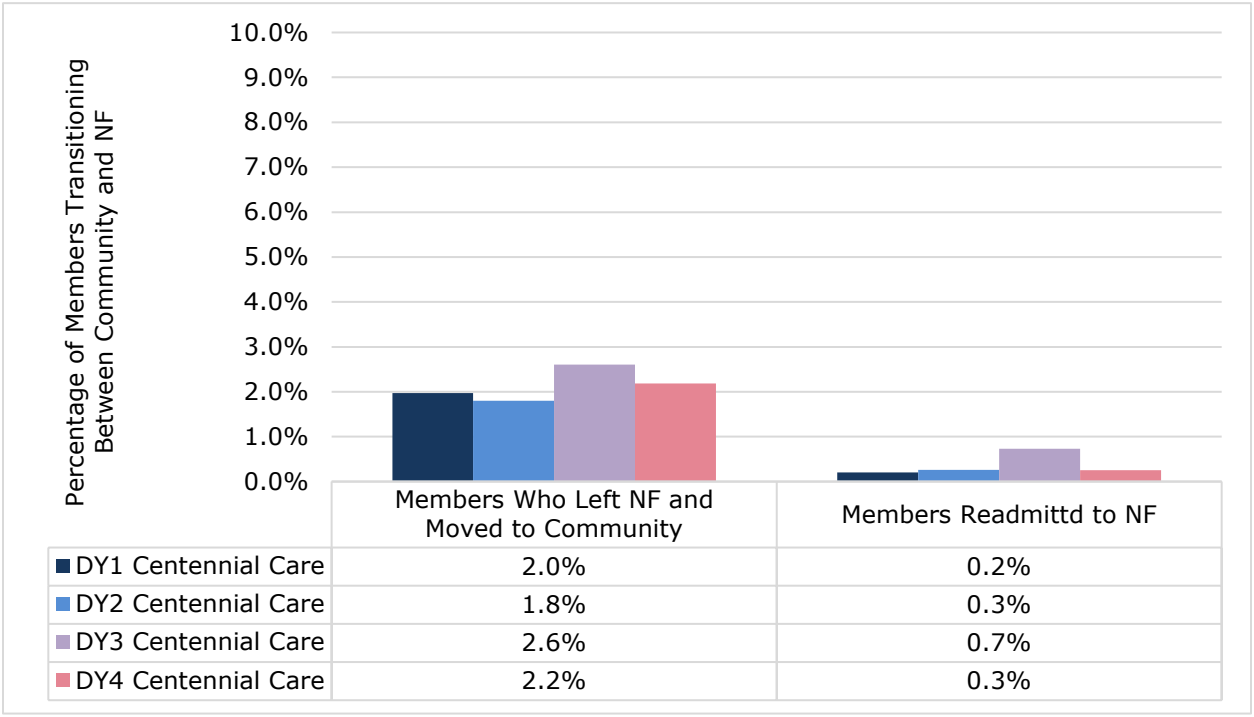
Measure 35 - Number and percentage of participants in Nursing Facility (NF) transitioning to community (HCBS).

Exhibits 35.a and 35.b present rates for DY1 through DY4 of the percentage and number of members who have transitioned between NF LOC and the community to use HCBS. Performance for DY3 and DY4 relied upon a supplemental MCO reports request to collect the necessary information. 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 increased from 2.0% to 2.2% from DY1 to DY4. The percentage of members who were readmitted into a NF increased slightly from 0.2% to 0.3% 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.

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

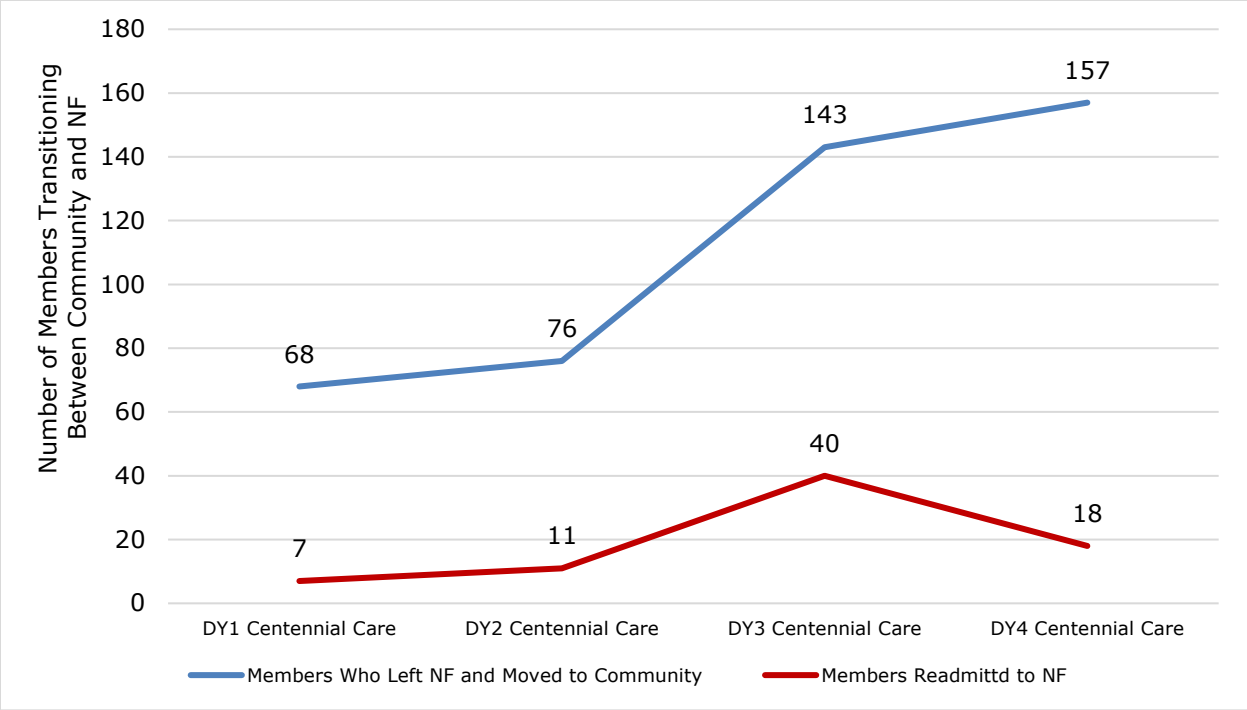
Exhibit 35.a – Percentage of Participants in Nursing Facility (NF) Transitioning to Community (HCBS)[50]



	Members Who Left NF and Moved to Community	Members Readmittd to NF
DY1 Centennial Care	2.0%	0.2%
DY2 Centennial Care	1.8%	0.3%
DY3 Centennial Care	2.6%	0.7%
DY4 Centennial Care	2.2%	0.3%

[50] Source: MCO reports for 2014 – 2015 (HSD/MAD 7) and supplemental ad hoc reports (based on HSD/MAD 7) for 2016 – 2017. 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.

Exhibit 35.b – Number of Participants in Nursing Facility (NF) Transitioning to Community (HCBS)[51]



[51] Source: MCO reports for 2014 – 2015 (HSD/MAD 7) and supplemental ad hoc reports (based on HSD/MAD 7) for 2016 – 2017. 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.

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

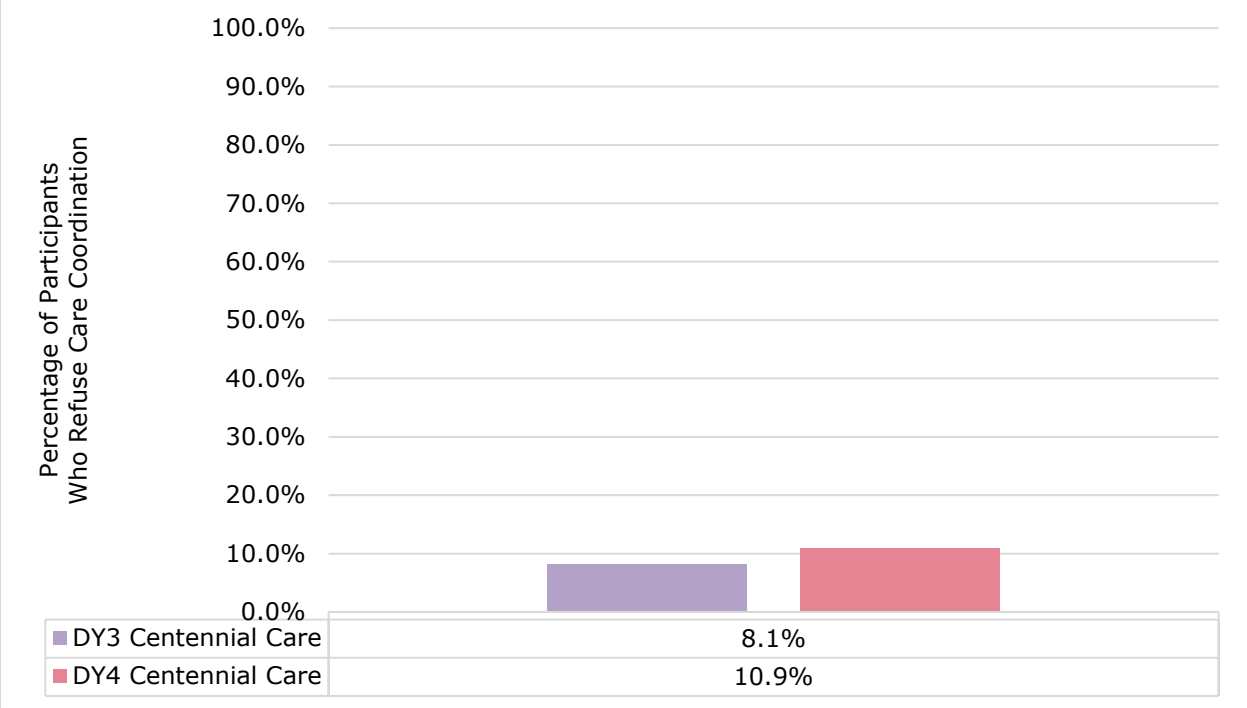
Exhibits 36.a and 36.b below present results for DY3 and DY4 for the percentage and number of participants who refused care coordination. A declining percentage of members who refused care coordination indicates a positive trend in the ability for MCOs to engage members in specialized programs. Note that the underlying data source for this data changed during DY3, and therefore only information from DY3 and forward was available for this analysis.

As illustrated, the percentage of members who refused to participate in care coordination increased from 8.1% to 10.9% from DY3 to DY4; despite the increase, the actual percentage of participants who refused care coordination were quite small overall.

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

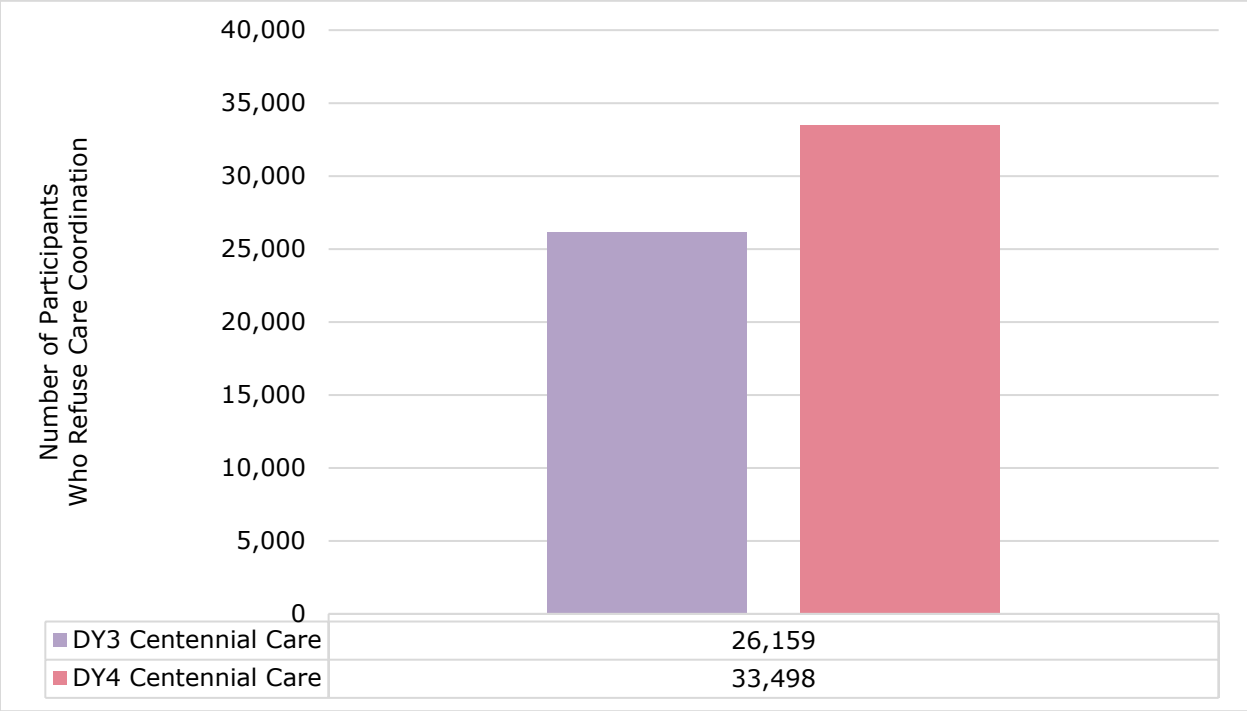
Statistical significance was not calculated for this measure due to the potential underlying differences in reporting methodology utilized by the MCOs.

Exhibit 36.a – Percentage of Participants Who Refused Care Coordination[52]



[52] Source: MCO reports for 2016 – 2017 (HSD/MAD ad hoc report).
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.

Exhibit 36.b – Number of Participants Who Refused Care Coordination[53]



[53] Source: MCO reports for 2016 – 2017 (HSD/MAD ad hoc report).
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.

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 DY4 of the Centennial Care program, the MCOs continue to improve quality of care as there were positive performance results across measures and within various subcomponents of measures, with rates improving in 11 out of 17 measures.

New Mexico saw improvement from the baseline[54] to DY4 in medication management for people with asthma; increases in asthma medication ratio among individual age cohorts; increases in monitoring rates of BMI for adults, children and adolescents; 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 all ACS measures (i.e., short and long term diabetes, asthma in younger adults and COPD or asthma in older adults, pediatric asthma, and hypertension) and a decline in the percentage of ER visits that were potentially avoidable. Downward trends for these measures are considered desirable.

Conversely, there was a decline in performance across measures and within various subcomponents in four out of 17 measures compared to the baseline. These measures include number of critical incidents, smoking and tobacco use cessation rates, a slight decline in annual patient monitoring for persistent medications, and Early Periodic Screening, Diagnostic and Treatment (EPSDT) screening ratios (although EPSDT ratios were much higher than national averages).

[54] 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.

Two measures experienced mixed results. For comprehensive diabetes care, there were improvements in 3 of 6 subcomponents from the baseline to DY4. Inpatient admissions to psychiatric hospitals and RTCs also showed mixed 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 37 – EPSDT screening ratio.

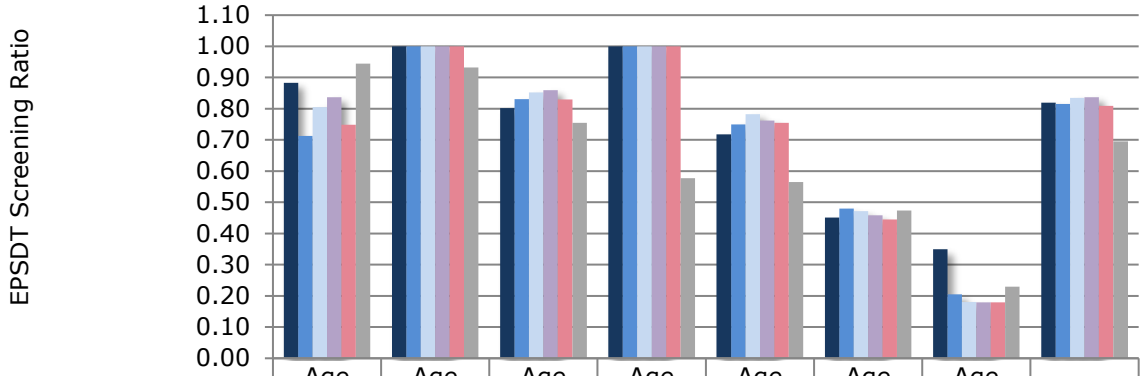
Exhibit 37 presents results for the Federal Fiscal Year (FFY) 2013 baseline through FFY 2017 and the EPSDT FFY 2017 national average[55] for the seven age cohorts and the aggregate rate for the measure EPSDT Screening Ratio. As illustrated, the screening ratio declined 3.3% for the aggregate total from FFY 2016 to FFY 2017. The 19-20 age cohort and 6-9 age cohort maintained consistent results, while the remaining subcomponents experienced declines ranging from 0.9% to 10.5%. The largest decrease in a subcomponent was in the <1 age cohort.

The total aggregate screening ratio declined 1.2% from the FFY 2013 baseline to FFY 2017. The largest increase in a subcomponent was experienced in the 10-14 age cohort at 5.1%, while the largest decrease experienced in a subcomponent was in the 19-20 age cohort at 48.6%.

Despite these declines, the total aggregate screening ratio for FFY 2017 was 11% higher than FFY 2017 national average ratio, which is a positive result.

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[56]



	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 2016	0.84	1.00	0.86	1.00	0.76	0.46	0.18	0.84
FFY 2017	0.75	1.00	0.83	1.00	0.75	0.44	0.18	0.81
FFY 2017 National Avg	0.94	0.93	0.75	0.58	0.57	0.47	0.23	0.70

[55] Source: CMS-416 Annual EPSDT Participation Report (National) Federal Fiscal Year 2017.

[56] Source: CMS-416 Reports for Federal Fiscal Years 2013 – 2017.
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.

Measure 38 – Annual monitoring for patients on persistent medication.

Exhibit 38 presents rates for the 2013 baseline through DY4 and the 2017 HEDIS Medicaid national average for the three subcomponent rates and the aggregate rate for the measure Annual Monitoring for Patients on Persistent Medication.

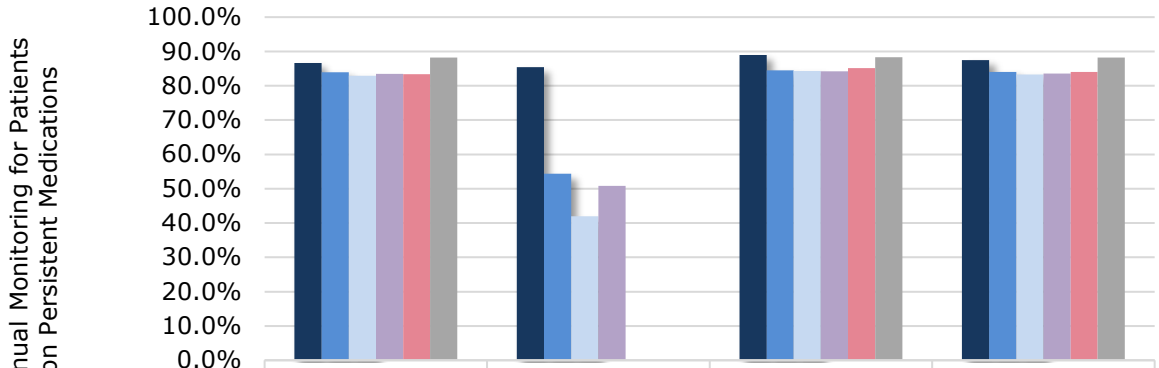
The diuretics subcomponent experienced a slight increase while the angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) subcomponent did not experience a change from DY3 to DY4. Note that the Digoxin subcomponent of the measure was discontinued by the NCQA for DY4. The aggregate percentage experienced a slight increase from DY3 to DY4. The changes from DY3 to DY4 were not statistically significant at the 95% confidence level.

Upon review of the individual MCO performance for the ACE inhibitors or ARBs subcomponent, UHC experienced the largest increase (1.5%) from DY3 to DY4 with PHP experiencing a slight increase (0.6%) over the same period. BCBS and PHP experienced declines of 1.8% and 0.5%, respectively. For the diuretic medications subcomponent, UHC, PHP, and MHC experienced increases (3.9%, 1.0%, and 0.1% respectively) while BCBS experienced a slight decline (-0.6%) from DY3 to DY4.

For the aggregate percentage, UHC experienced the largest increase (2.5%) while PHP experienced a 0.9% increase from DY3 to DY4. BCBS and MHC both experienced decreases of 1.2% and 0.1% respectively from DY3 to DY4.

The percentage for all subcomponents and the aggregate percentage declined from the baseline to DY4. The diuretic subcomponent experienced the steepest decline (-4.4%), while the ACE inhibitors (or ARBs) declined 3.6%. The aggregate rate declined by 4.0%. All decreases were statistically significant at the 95% confidence level.

Exhibit 38 – Annual Monitoring for Patients on Persistent Medications[57]



	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%
DY3 Centennial Care	83.4%	50.8%	84.2%	83.6%
DY4 Centennial Care	83.4%	N/A	85.2%	84.0%
2017 National Avg	88.2%	N/A	88.3%	88.2%

[57] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measure "mpm").
Note that the Digoxin subcomponent was no longer included in HEDIS reporting for DY4. In addition, the NCQA did not publish a 2017 national average for Medicaid HMO.
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.

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

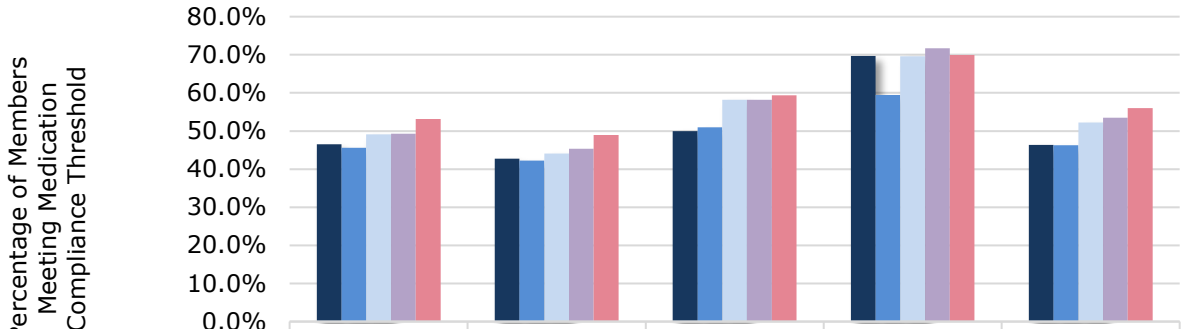
Exhibit 39 presents rates for the 2013 baseline through DY4 for the four age cohorts and the aggregate rate for the measure Medication Management for People with Asthma. As illustrated, percentages increased in the 5-11, 12-18, and 19-50 age cohorts and in the aggregate from DY3 to DY4. The largest increases were in the 5-11 and 12-18 age cohorts (both increasing 7.9%), which were statistically significant at a 95% confidence level. The aggregate rate increased by 4.7%, which was statistically significant at a 95% confidence interval.

MHC, PHP, and UHC experience an aggregate percentage increase from DY3 to DY4. PHP and MHC experienced the largest increase at 8.6% and 8.5% respectively, while UHC increased 1.0% and BCBS decreased 8.0%. Each MCO experienced their largest increase in varied age cohorts (BCBS 4.9% in 5-11, MHC 11.6% in 5-11, PHP 17.5% in 51-64, and UHC 7.2% in 12-18).

The aggregate rate experienced an increase from baseline to DY4 of 20.9%, which was statistically significant at a 95% confidence level. The 19-50 age cohort experienced the largest improvement of 18.7% followed by 12-18 (14.5%) and 5-11 (14.3%).

Upon review of the individual MCO performance from the baseline to DY4, the total aggregate increased for PHP (23.9%), MHC (23.0%), and BCBS (6.2%) while UHC experienced a slight decrease (-0.1%), although UHC's DY4 result was the highest among MCOs.

Exhibit 39 – Medication Management for People with Asthma[58]



	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%
DY3 Centennial Care	49.3%	45.3%	58.2%	71.7%	53.5%
DY4 Centennial Care	53.2%	48.9%	59.3%	69.9%	56.0%

[58] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measure "mma").
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.

Measure 40 – Asthma medication ratio.

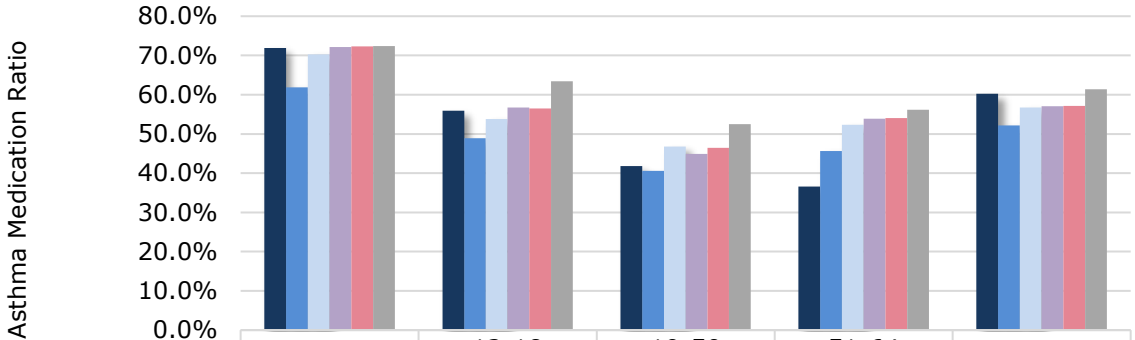
Exhibit 40 presents rates for the 2013 baseline through DY4 and the 2017 HEDIS Medicaid national average for the four age cohorts and the aggregate percentage for the measure Asthma Medication Ratio. As illustrated, the 5-11, 19-50, and 51-64 age cohorts increased from DY3 to DY4. The largest improvement was a 3.5% increase for the 19-50 age cohort. None of the changes were statistically significant at the 95% confidence level.

UHC, PHP, and MHC experienced increases in aggregate from DY3 to DY4 by 8.4%, 1.6%, and 0.1% respectively. For those MCOs, the 19-50 age cohort experienced the largest increases. The only increase experienced for BCBS was in the 5-11 age cohort at 3.3%. The BCBS aggregate percentage decreased 6.1% from DY3 to DY4.

All four age cohorts experienced increases from the baseline to DY4. The largest increase was for the 51-64 age cohort (47.6%), a statistically significant change at the 95% confidence level. The total aggregate from baseline to DY4 decreased 5.2% which was statistically significant at the 95% confidence level.

UHC's total aggregate percentage increased 36.3%, which was statistically significant at the 95% confidence level. During the same reporting period, the aggregate percentage decreased for MHC (-0.8%), PHP (-4.5%), and BCBS (-27.1%). The decrease for BCBS was statistically significant change at the 95% confidence level.

Exhibit 40 – Asthma Medication Ratio[59]



	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%
DY3 Centennial Care	72.2%	56.8%	44.9%	53.9%	57.1%
DY4 Centennial Care	72.3%	56.5%	46.5%	54.1%	57.1%
2017 National Avg	72.4%	63.4%	52.5%	56.2%	61.4%

[59] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measure "amr").
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.

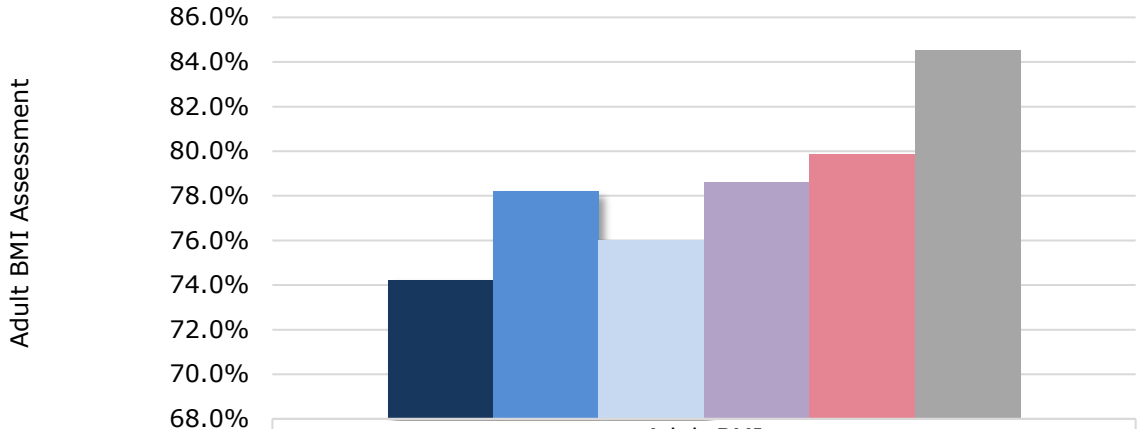
Measure 41 – Adult BMI assessment and weight assessment for children/adolescents.

Exhibit 41.a presents rates for the 2013 baseline through DY4 and the 2017 HEDIS Medicaid national average for the measure Adult BMI Assessment. As illustrated, the percentage increased modestly from DY3 to DY4 (1.6%). Upon review of the individual MCO performance from DY3 to DY4, BCBS, PHP, and UHC, experienced increases of 4.5%, 1.0%, and 5.1% respectively while MHC experienced a decrease of 6.9%. None of the changes were statistically significant at the 95% confidence level.

The percentage increased from the baseline to DY4 (7.6%) and was statistically significant at the 95% confidence level. Upon review of the individual MCO performance from baseline to DY4, BCBS, PHP, and UHC experienced increases of 11.0%, 14.7%, and 14.3% respectively while MHC experienced a decrease of 8.9%. All percentage changes were statistically significant at the 95% confidence level.

The DY4 rate was below the 2017 HEDIS Medicaid national average.

Exhibit 41.a – Adult BMI Assessment[60]



	Adult BMI
2013 Baseline	74.2%
DY1 Centennial Care	78.2%
DY2 Centennial Care	76.0%
DY3 Centennial Care	78.6%
DY4 Centennial Care	79.9%
2017 National Average	84.5%

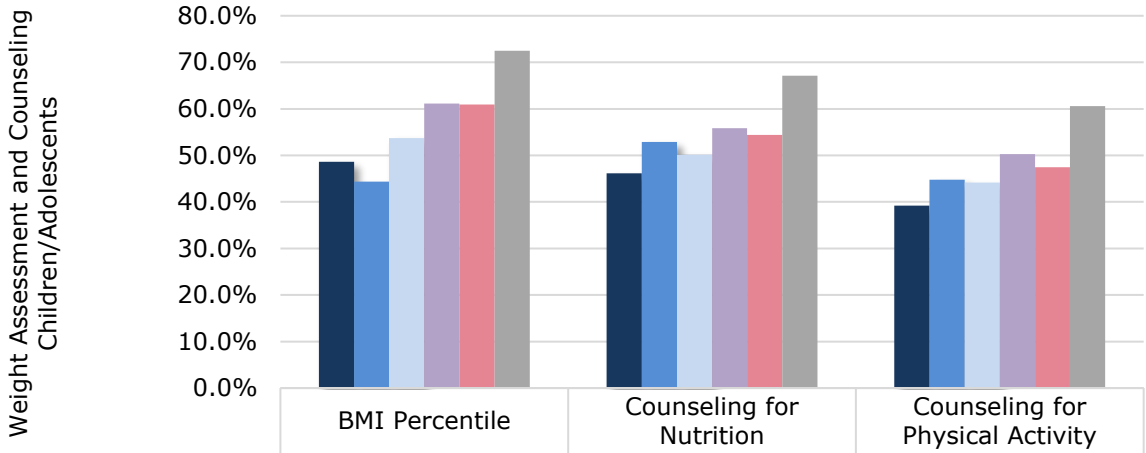
[60] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measure "bmi").
In the context of this report, discussions of changes in measure values between periods are based on the percent change (increase/decrease) which is calculated as [Current period measure value] / [Prior period measure value] – 1.

Exhibit 41.b presents rates for the 2013 baseline through DY4 for the three subcomponents included in the measure Weight Assessment for Children/Adolescents. As illustrated, all three sub components experienced decreases from DY3 to DY4, the largest of which was counseling for physical activity at 5.6%. None of the decreases were statistically significant at the 95% confidence level.

However, there were improvements in all three subcomponents from the baseline to DY4. The largest improvement was in the rate for BMI percentile (25.4%), followed by counseling for physical activity (20.9%), and then counseling for nutrition (17.8%). The increases in all three rates were statistically significant at the 95% confidence level.

DY4 rates were below the 2017 HEDIS Medicaid national averages for all three subcomponents.

Exhibit 41.b – Weight Assessment for Children/Adolescents[61]



	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%
DY3 Centennial Care	61.1%	55.9%	50.3%
DY4 Centennial Care	60.9%	54.4%	47.4%
2017 National Average	72.5%	67.1%	60.6%

[61] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measure "wcc").
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.

Measure 42 – Comprehensive diabetes care.

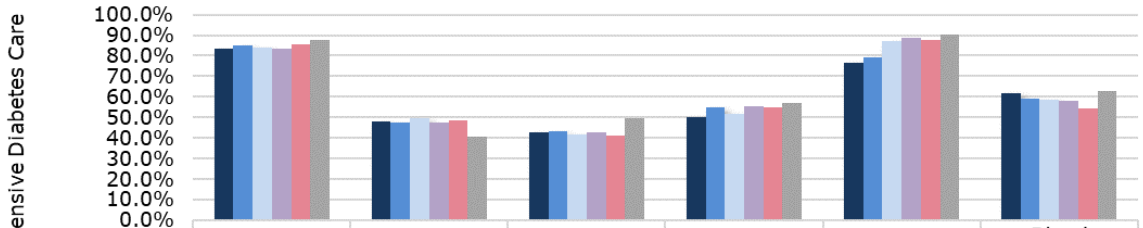
Exhibit 42 presents rates for the 2013 baseline through DY4 and the 2017 HEDIS Medicaid national averages for the six subcomponents included in Comprehensive Diabetes Care.

The only subcomponent that experienced an increase from DY3 to DY4 was Hemoglobin A1c (HbA1c) testing, which increased 2.6%. HbA1c control (<8.0%) decreased 3.5% and HbA1c poor control (>9.0%) experienced a negative increase of 1.6%. Eye Exam and Medical Attention for Nephropathy both decreased 1.3%. The largest decrease experienced was in the blood pressure controlled subcomponent at 6.3%, which was statistically significant at a 95% confidence level.

Three subcomponents experienced increases from baseline to DY4. Medical attention for nephropathy was the largest increase at 14.4% which was statistically significant at the 95% confidence level. The other two components that experienced increases were eye exams at 8.6% and HbA1c testing 2.7%. Blood pressure controlled experienced the largest decrease at 12.0%.

PHP, MHC, and BCBS experienced their largest increases from the baseline to DY4 in the subcomponent medical attention for nephropathy at 20.2%, 13.4%, and 14.5% respectively. UHC experienced their largest increase in eye exams at 27.8%. These increases were all statistically significant at the 95% confidence level.

Exhibit 42 – Comprehensive Diabetes Care[62]



	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%
DY3 Centennial Care	83.5%	47.6%	42.5%	55.4%	88.7%	58.2%
DY4 Centennial Care	85.7%	48.4%	41.0%	54.7%	87.6%	54.5%
2017 National Avg	87.6%	40.5%	49.4%	57.2%	90.1%	62.7%

[62] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measure "cdc").
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.

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

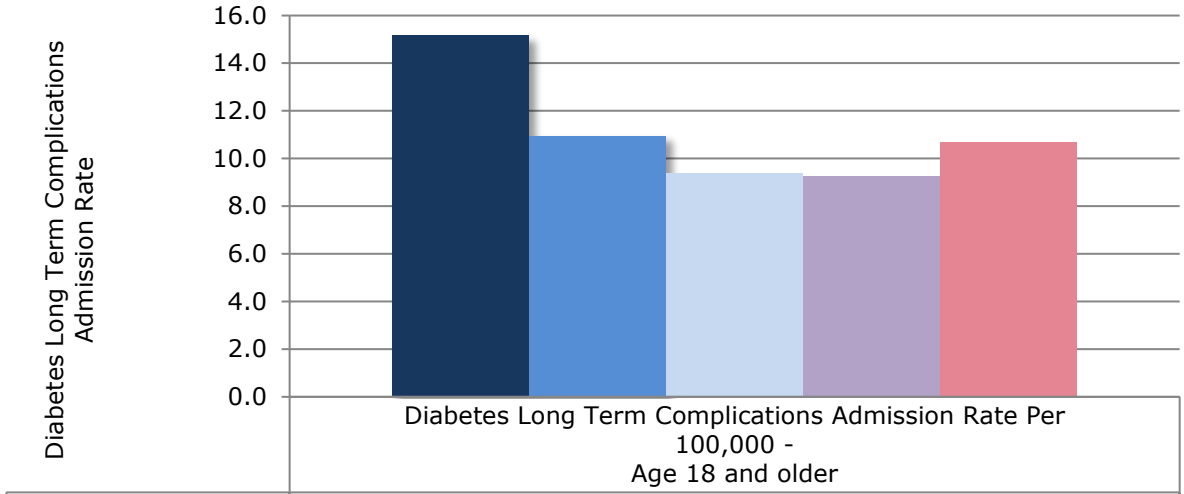
Exhibit 43.a presents results for the baseline through DY4 for Ambulatory Care Sensitive Diabetes Long Term Complications Admission Rates. As illustrated, there was a decline in performance resulting in a 15.1% increase in the rate per 100,000 with admissions due to long term complications from diabetes from DY3 to DY4.

Overall there was an improvement in performance resulting in a 29.7% decrease in the rate per 100,000 with admissions due to long term complications from diabetes from the baseline to DY4 which is a very positive outcome.

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[63]



	Diabetes Long Term Complications Admission Rate Per 100,000 - Age 18 and older
2013 Baseline	15.2
DY1 Centennial Care	10.9
DY2 Centennial Care	9.4
DY3 Centennial Care	9.3
DY4 Centennial Care	10.7

[63] Source: ACS MMIS reports for 2013 – 2017. Note that DY2 MMIS information for this measure was refreshed after the Interim Report was finalized; therefore, DY2 results have been updated to reflect more current information. In addition, claims analysis criteria was revised between DY2 and DY3 to account for the ICD-9 changeover to ICD-10.
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.

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

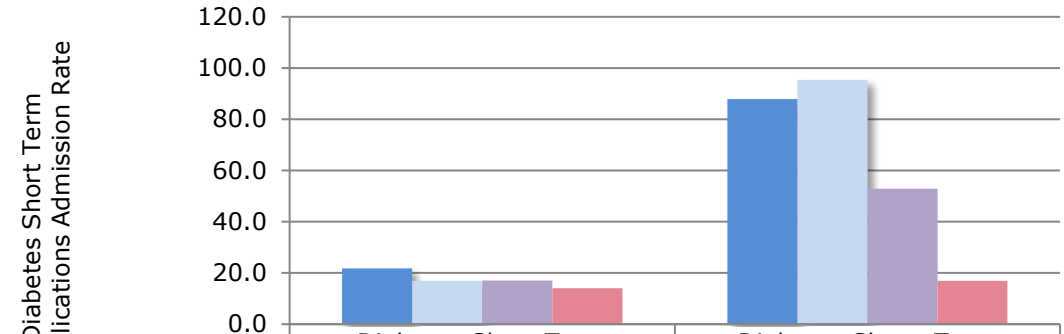
Exhibit 43.b presents results for DY1 through DY4 for Ambulatory Care Sensitive Diabetes Short Term Complications Admission Rates. As illustrated, there was an improvement in performance resulting in a 17.8% decrease in the rate per 100,000 for members 18-64 years of age with admissions due to short term complications from diabetes from DY3 to DY4. For members 65 years of age and older, performance also improved resulting in a 68.0% decrease in the rate per 100,000 from DY3 to DY4.

Overall there was an improvement in performance resulting in a 35.4% decrease in the admission rate per 100,000 for members 18-64 years of age from DY1 to DY4. Members 65 years of age and older experienced a similar positive outcome, with a decrease of 80.7% in the admission rate per 100,000 members from DY1 to DY4.

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[64]



	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
DY3 Centennial Care	17.1	52.9
DY4 Centennial Care	14.0	16.9

[64] Source: Centennial Care Diabetes Inpatient Encounters (PQI) reports and MMIS reports. Note that claims analysis criteria was revised between DY2 and DY3 to account for the ICD-9 changeover to ICD-10.
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.

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

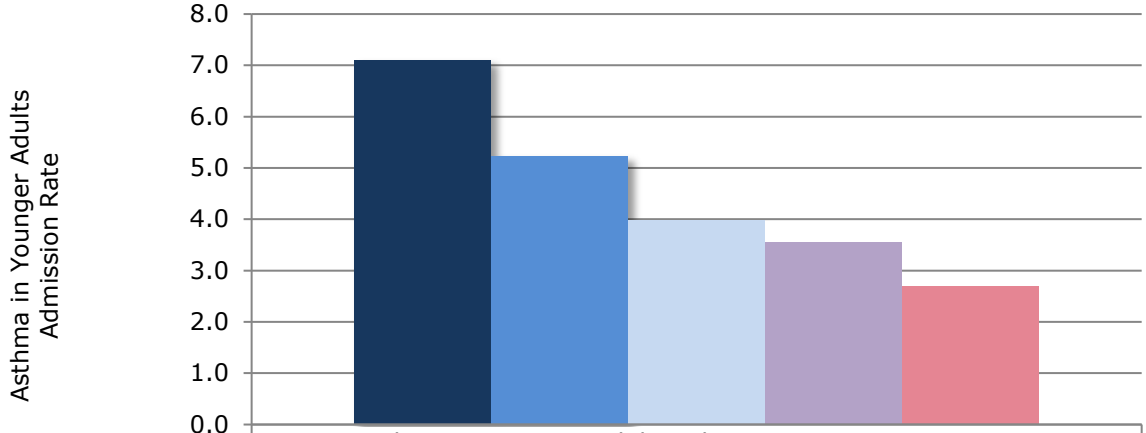
Exhibit 44.a presents results for the 2013 baseline through DY4 for ACS Admission Rates for Asthma in Younger Adults. As illustrated, there was an increase in performance resulting in a 23.9% decrease in the asthma admission rate per 100,000 for members in the 18-39 age cohort from DY3 to DY4.

Upon review of the individual MCO performance over the same reporting period, MHC, PHP and UHC experienced increases in performance with a decrease in admissions at 52.6%, 6.1%, and 2.8% respectively.

There was also an improvement in performance resulting in a 62.0% decline in the rate per 100,000 from the baseline to DY4, which was statistically significant at the 95% confidence level.

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

Exhibit 44.a – Asthma in Younger Adults Admission Rate[65]



	Asthma in Younger Adults Admission Rate Per 100,000 - Ages 18 to 39
2013 Baseline	7.1
DY1 Centennial Care	5.2
DY2 Centennial Care	4.0
DY3 Centennial Care	3.6
DY4 Centennial Care	2.7

Exhibit 44.b presents results for the 2013 baseline through DY4 for ACS Admission Rates for COPD or Asthma in Older Adults. As illustrated, there was an improvement in performance resulting in a 12.0% decrease in the COPD or asthma admission rate per 100,000 for members in the 40-64 age cohort from DY3 to DY4. In contrast, there was a decline in performance resulting in a 4.4% increase in the COPD or asthma admission rate per 100,000 for members in the 65+ age cohort over the same reporting period. Neither of these changes were statistically significant at the 95% confidence level.

Upon review of the individual MCO performance over the same reporting period, PHP, MHC, and BCBS experienced increases in performance for members in the 40-64 age cohort with declines in admissions of 39.4%, 14.1%, and 1.9% respectively. MCO performance was stable for members in

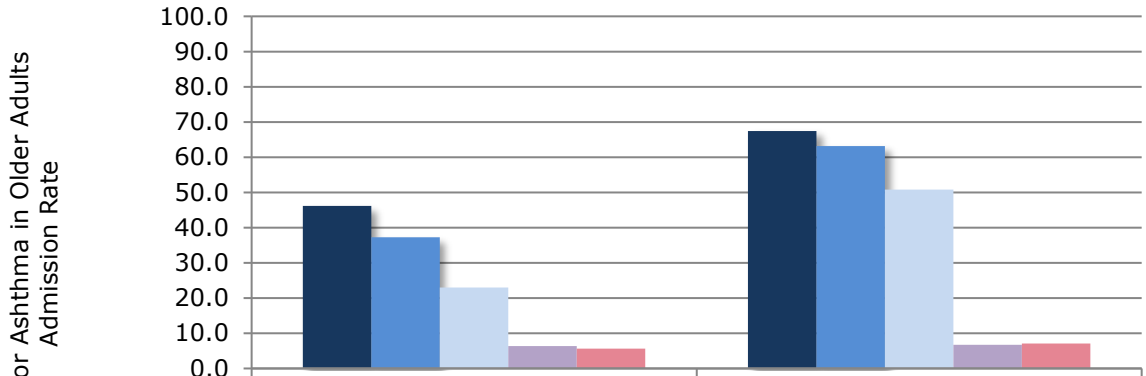
[65] Source: ACS MMIS reports (COPD) from 2013 – 2017. Note that claims analysis criteria was revised between DY2 and DY3 to account for the ICD-9 changeover to ICD-10.
In the context of this report, discussions of changes in measure values between periods are based on the percent change (increase/decrease) which is calculated as [Current period measure value] / [Prior period measure value] – 1.

the 65+ age cohort, with the exception being UHC which experienced a decline in performance resulting in an 8.2% increase in admission rates.

There was an improvement in performance in the admission rates per 100,000 for members in the 40-64 age cohort (-87.9%) and for members in the 65+ age cohort (-89.5%) from the baseline to DY4. Both outcomes were statistically significant at the 95% confidence level.

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

Exhibit 44.b – COPD or Asthma in Older Adults Admission Rate[66]



	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+
2013 Baseline	46.1	67.5
DY1 Centennial Care	37.2	63.2
DY2 Centennial Care	23.0	50.8
DY3 Centennial Care	6.4	6.8
DY4 Centennial Care	5.6	7.1

[66] Source: ACS MMIS reports (COPD) from 2013 – 2017. Note that claims analysis criteria was revised between DY2 and DY3 to account for the ICD-9 changeover to ICD-10.
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.

Measure 45 – Ambulatory care sensitive admission rates for hypertension.

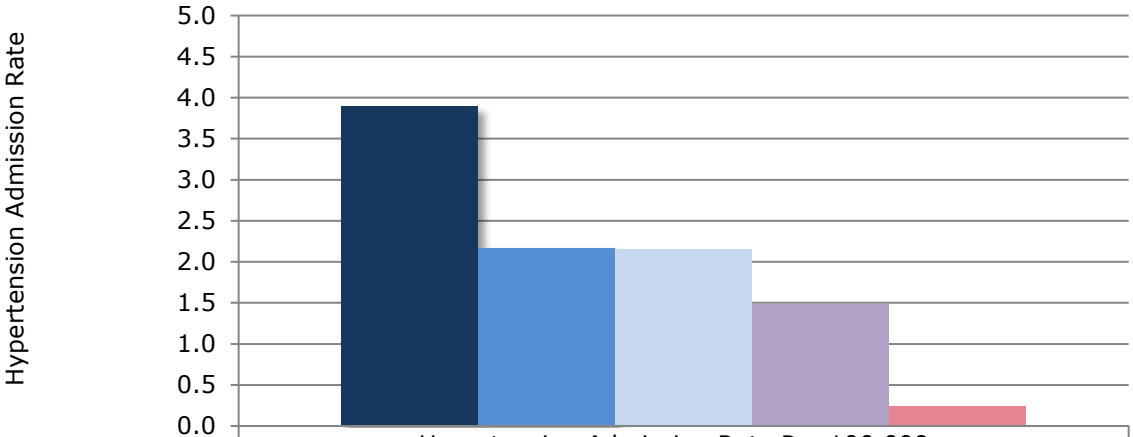
Exhibit 45 presents results for the 2013 baseline through DY4 for Ambulatory Care Sensitive Admission Rates for Hypertension. As illustrated, there was a positive decline of 84.0% in the admission rate per 100,000 for members with admissions due to hypertension from DY3 to DY4, which was statistically significant at the 95% confidence level.

There was an improvement in individual MCO performance over the same reporting period for all MCOs, resulting in a decrease in rate per 100,000 for members with admissions due hypertension: BCBS (-86.0%), MHC (-89.1%), PHP (-69.5%), and UHC (-83.7%).

There was also an improvement in performance resulting in a 93.9% decrease in the rate per 100,000 with admissions due to hypertension from the baseline to DY4, which was statistically significant at the 95% confidence level.

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

Exhibit 45 – Hypertension Admissions Rate[67]



	Hypertension Admission Rate Per 100,000 - Ages 18 and Older
2013 Baseline	3.9
DY1 Centennial Care	2.2
DY2 Centennial Care	2.2
DY3 Centennial Care	1.5
DY4 Centennial Care	0.2

[67] Source: ACS MMIS reports for Hypertension for 2013 - 2017. Note that claims analysis criteria was revised between DY2 and DY3 to account for the ICD-9 changeover to ICD-10.
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.

Measure 46 – ACS admission rates for pediatric asthma.

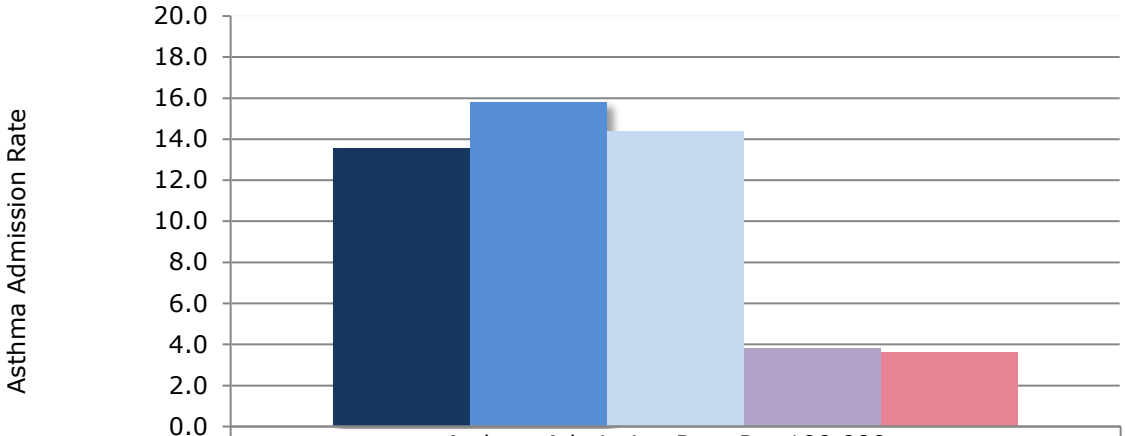
Exhibit 46 presents rates for the 2013 baseline through DY4 for the ACS Pediatric Asthma Admission measure for members in the 2-17 age cohort. Similar to other admission rate measures, this is an inverse measure where a decreasing rate represents an improvement in performance. As illustrated, there was an improvement in performance resulting in a 4.3% decrease in the in the rate per 100,000 with admissions for pediatric asthma from DY3 to DY4.

Upon review of individual MCO performance during this same reporting period, three MCOs experienced increased performance with decreases in admission rates.

There was also an increase in performance resulting in a 73.2% decrease in admission rate from the baseline to DY4, which was statistically significant at the 95% confidence level.

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

Exhibit 46 – ACS Admissions Rate for Pediatric Asthma Aggregate[68]



	Asthma Admission Rate Per 100,000 - Ages 2 to 17
2013 Baseline	13.6
DY1 Centennial Care	15.8
DY2 Centennial Care	14.4
DY3 Centennial Care	3.8
DY4 Centennial Care	3.6

[68] Source: ACS MMIS reports (Pediatric Asthma) for 2013 – 2017. Note that claims analysis criteria was revised between DY2 and DY3 to account for the ICD-9 changeover to ICD-10.
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.

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

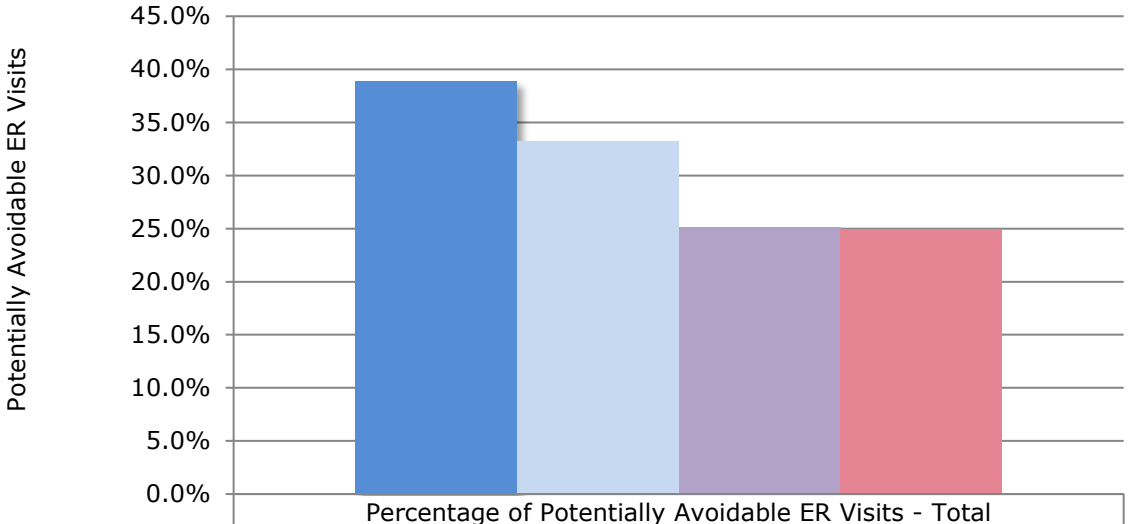
Exhibit 47.a presents results for DY1 through DY4 for the Percentage of Unduplicated Members with Potentially Avoidable ER Visits. As illustrated, there was a 0.8% decline in the percentage of unduplicated members with a potentially avoidable ER visit out of the total number of ER visits from DY3 to DY4.

Overall there was a 35.8% decrease in percentage of unduplicated members with a potentially avoidable ER visit out of the total number of ER visits from DY1 through DY4, a positive outcome.

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[69]



	Percentage of Potentially Avoidable ER Visits - Total
DY1 Centennial Care	38.8%
DY2 Centennial Care	33.2%
DY3 Centennial Care	25.1%
DY4 Centennial Care	24.9%

[69] Source: MCO reports for 2014 – 2017 (HSD/MAD 40; MHC and PHP reported using ad hoc reports in DY4).
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.

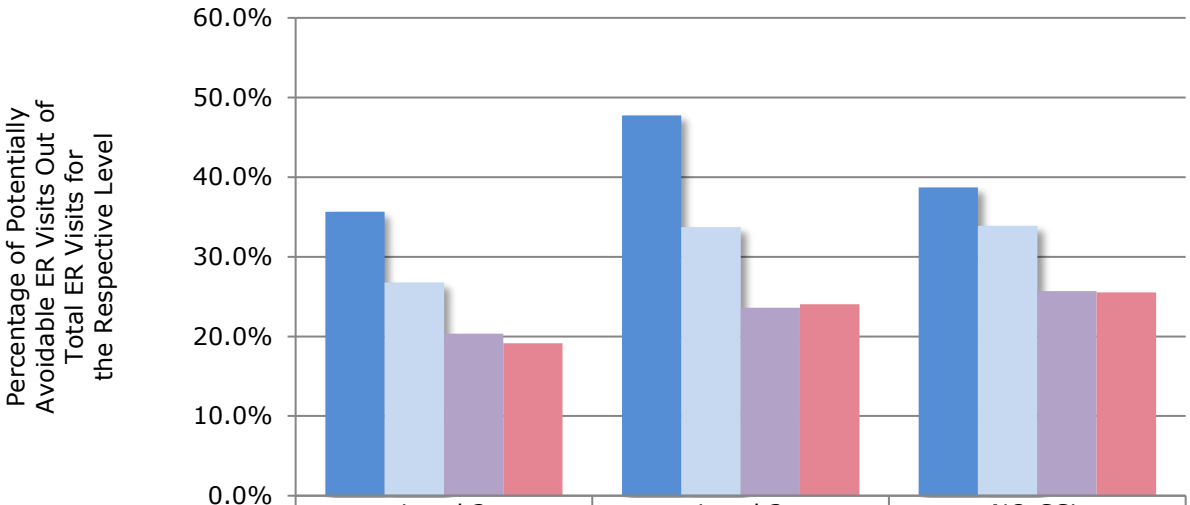
Exhibit 47.b presents results for DY1 through DY4 for the Percentage of Unduplicated Members with Non-Emergent ER Visits by Care Coordination Level out of the Total Number of ER Visits by Level. As illustrated, there was a decrease in percentage of non-emergent ER visits in Care Coordination Level 2 (-6.1%) and members with no care coordination level (-0.6%), but an increase in Level 3 (2.4%) from DY3 to DY4.

Overall, all care coordination levels experienced a decrease in the percentage of unduplicated members with non-emergent ER visits (Level 2 at -47.1%, Level 3 at -50.6%, and No CCL at -34.0%).

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 47.b – Percentage of Members with Potentially Avoidable ER Visits out of the Total Number of ER Visits by Care Coordination Level[70]



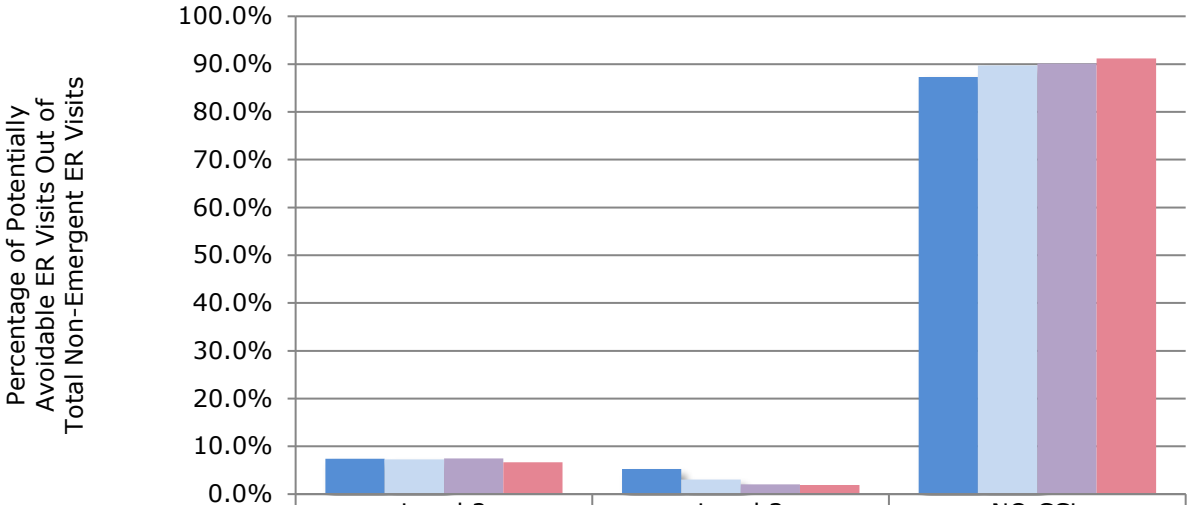
	Level 2	Level 3	NO CCL
DY1 Centennial Care	35.7%	47.8%	38.7%
DY2 Centennial Care	26.8%	33.7%	33.9%
DY3 Centennial Care	20.3%	23.6%	25.7%
DY4 Centennial Care	19.1%	24.0%	25.5%

[70] Source: MCO reports for 2014 – 2017 (HSD/MAD 40; MHC and PHP reported using ad hoc reports in DY4).
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.

Exhibit 47.c presents results for DY1 through DY4 for the Distribution of Non-Emergent ER Visits by Care Coordination Level. As illustrated, there were reductions in percentage of Non-Emergent ER visits in Care Coordination Level 2 (-10.9%) and Level 3 (-8.3%), while the percentage for members with no Care Coordination Level increased by 1.1%.

From DY1 through DY4 the same trend continued with a decrease in percentage for Level 2 (-4.1%) and Level 3 (-34.5%) while no Care Coordination Level increased by 3.8%.

Exhibit 47.c – Distribution of Potentially Avoidable ER Visits by Care Coordination Level out of the Total Number of Non-Emergent ER Visits[71]



	Level 2	Level 3	NO CCL
DY1 Centennial Care	7.4%	5.3%	87.3%
DY2 Centennial Care	7.3%	3.0%	89.7%
DY3 Centennial Care	7.5%	2.1%	90.1%
DY4 Centennial Care	6.6%	1.9%	91.2%

[71] Source: MCO reports for 2014 – 2017 (HSD/MAD 40; MHC and PHP reported using ad hoc reports in DY4). Note that the distribution may not equal exactly 100% in each year due to rounding.
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.

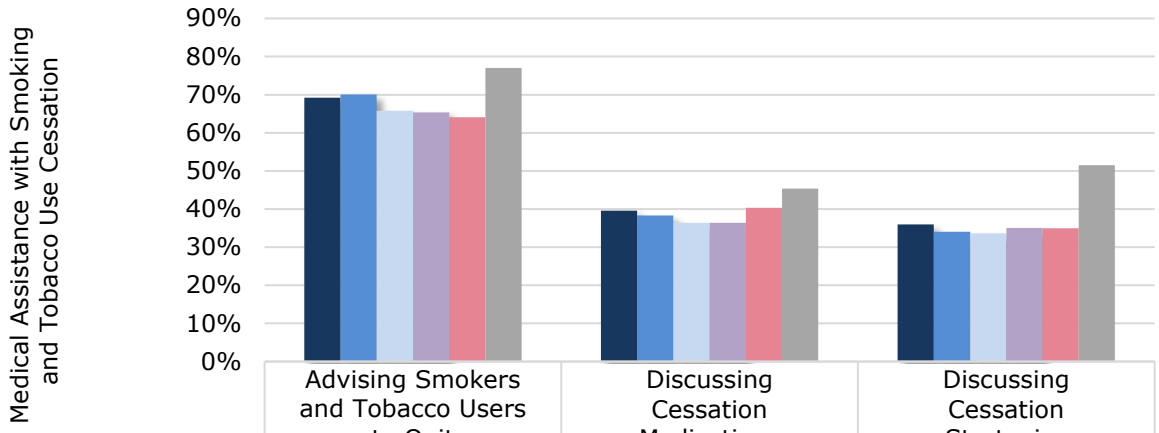
Measure 48 – Medical assistance with smoking and tobacco use cessation.

Exhibit 48 presents results for the baseline through DY4 2017 CAHPS 5.0H national average for the three subcomponents for the Medical Assistance with Tobacco Use Cessation measure. As illustrated, the percentage of members who received advice to quit experienced a decrease by 2% from DY3 and DY4 and there was an 11% increase in the percentage of members who discussed or were recommended cessation medications during the same period. The percentage of members who discussed cessation strategies during remained relatively consistent from DY3 to DY4.

From the baseline to DY4, the subcomponent discussing cessation medications experienced a 2% increase while decreases were experienced for the subcomponent advising smokers to quit and the subcomponent discussing cessation strategies (-7% and -3% respectively).

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[72]



	Advising Smokers and Tobacco Users to Quit	Discussing Cessation Medications	Discussing Cessation Strategies
2013 Baseline	69%	40%	36%
DY1 Centennial Care	70%	38%	34%
DY2 Centennial Care	66%	36%	34%
DY3 Centennial Care	65%	36%	35%
DY4 Centennial Care	64%	40%	35%
2017 National Avg	77%	45%	52%

[72] Source: MCO CAHPS reports for 2013 – 2017.
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.

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

Exhibit 49.a presents results for DY1 through DY4 for Number of Critical Incidents by Reporting Category for Centennial Care. As illustrated, for DY4 the three categories with the largest number of critical incidents were Emergency Services, Death, and Neglect. As a proportion of total incidents, Neglect incidents increased by 3.5% while Death and Emergency Service incidents decreased by 8.3% and 0.1% respectively from DY3 to DY4.

Upon review of the individual MCO performance during the same reporting period, BCBS experienced the largest decrease in Law Enforcement incidents at 29.9% and the largest increase in Missing/Elopement incidents at 75.2%. MHC experienced the largest decrease in missing/elopement incidents at 30.8% and the largest increase in neglect incidents at 63.0%. PHP experienced the largest decrease in law enforcement incidents at 52.1% and the largest increase in emergency services incidents at 15.1%. UHC experienced the largest decrease in missing/elopement incidents at 45.2% and the largest increase in death incidents at 29.4%.

A national average could not be identified for comparison to the DY4 Centennial Care rate.

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

Exhibit 49.a – Critical Incident Reports for Centennial Care[73]

Measure	Centennial Care - DY1		Centennial Care - DY2			Centennial Care - DY3			Centennial Care - DY4		
	# Members	Centennial Care Percent per Incident Type	# Members	Centennial Care Percent per Incident Type	DY1 - DY2 % Change	# Members	Centennial Care Percent per Incident Type	DY2 - DY3 % Change	# Members	Centennial Care Percent per Incident Type	DY3 - DY4 % Change
Abuse	957	9.8%	875	7.2%	-26.5%	727	5.1%	-29.4%	1,107	6.2%	22.9%
Death	1,058	10.8%	1,433	11.8%	8.9%	1,534	10.7%	-9.0%	1,743	9.8%	-8.3%
Natural/Expected	945	89.3%	1,246	87.0%	-2.7%	1,394	90.9%	4.5%	1,574	90.3%	-0.6%
Unexpected	106	10.0%	169	11.8%	17.7%	130	8.5%	-28.1%	160	9.2%	8.3%
Homicide	5	0.5%	5	0.3%	-26.2%	0	0.0%	NA	0	0.0%	0.0%
Suicide	2	0.2%	13	0.9%	379.9%	10	0.7%	-28.1%	9	0.5%	-20.8%
Emergency Services	5,733	58.6%	7,329	60.2%	2.8%	9,258	64.6%	7.4%	11,464	64.6%	-0.1%
Environmental Hazard	179	1.8%	208	1.7%	-6.6%	264	1.8%	7.9%	282	1.6%	-13.8%
Exploitation	461	4.7%	441	3.6%	-23.1%	408	2.8%	-21.3%	508	2.9%	0.5%
Law Enforcement	447	4.6%	511	4.2%	-8.1%	330	2.3%	-45.1%	326	1.8%	-20.3%
Missing/Elopement	94	1.0%	161	1.3%	37.7%	77	0.5%	-59.3%	108	0.6%	13.2%
Neglect	861	8.8%	1,212	10.0%	13.1%	1,729	12.1%	21.3%	2,218	12.5%	3.5%
Total Number of Critical Incidents	**9,790**		**12,170**			**14,327**			**17,756**		

[73] Source: HSD/MAD Annual Report. Note that this source changed from MCO Critical Incident reports since the Interim Report to be consistent with final numbers published by HSD/MAD. Actual differences in numbers between sources are immaterial to results.

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.

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

Exhibit 49.b presents results for DY1 through DY4 for Number of Critical Incidents by Reporting Category for the Behavioral Health subcomponent. As illustrated, for DY4 the three categories with the largest number of critical incidents were Emergency Services, Abuse, and Neglect. As a proportion of total incidents, Neglect incidents increased by 152.7% while Emergency Service and Abuse incidents decreased by 8.8% and 10.8% respectively from DY3 to DY4.

Upon review of the individual MCO performance during the same reporting period, BCBS, MHC, and UHC experienced decreases in the proportion of critical incidents for the largest category, emergency services, by 17.1%, 11.1%, and 21.3% respectively. For all MCOs, neglect incidents increased as a proportion of total incidents with UHC having the largest increase of 301.2%.

A national average could not be identified for comparison to the DY4 Centennial Care rate.

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) [74]

Measure	Behavioral Health - DY1		Behavioral Health - DY2			Behavioral Health - DY3			Behavioral Health - DY4		
	# Members	Centennial Care Percent per Incident Type	# Members	Centennial Care Percent per Incident Type	DY1 - DY2 % Change	# Members	Centennial Care Percent per Incident	DY2 - DY3 % Change	# Members	Centennial Care Percent per Incident	DY3 - DY4 % Change
Abuse	310	33.8%	223	21.2%	-37.4%	420	20.2%	-4.9%	324	18.0%	-10.8%
Death	33	3.6%	54	5.1%	42.5%	106	5.1%	-0.9%	79	4.4%	-13.8%
Natural/Expected	23	69.7%	30	55.6%	-20.3%	90	84.9%	52.8%	53	67.1%	-21.0%
Unexpected	8	24.2%	21	38.9%	60.4%	16	15.1%	-61.2%	22	27.8%	84.5%
Homicide	2	6.1%	1	1.9%	-69.4%	0	0.0%	-100.0%	0	0.0%	0.0%
Suicide	0	0.0%	2	3.7%	NA	0	0.0%	-100.0%	4	5.1%	NA
Emergency Services	309	33.7%	496	47.1%	39.8%	1,221	58.6%	24.3%	963	53.4%	-8.8%
Environmental Hazard	6	0.7%	0	0.0%	-100.0%	19	0.9%	NA	13	0.7%	-20.9%
Exploitation	7	0.8%	14	1.3%	74.1%	36	1.7%	29.9%	25	1.4%	-19.7%
Law Enforcement	132	14.4%	143	13.6%	-5.7%	93	4.5%	-67.2%	55	3.1%	-31.6%
Missing/Elopement	61	6.7%	46	4.4%	-34.3%	48	2.3%	-47.3%	37	2.1%	-10.9%
Neglect	58	6.3%	68	6.5%	2.1%	140	6.7%	4.0%	306	17.0%	152.7%
Total Number of Critical Incidents	**916**		**1,044**			**2,083**			**1,802**		

[74] Source: HSD/MAD Annual Report. Note that this source changed from MCO Critical Incident reports since the Interim Report to be consistent with final numbers published by HSD/MAD. Actual differences in numbers between sources are immaterial to results.

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.

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

Exhibit 49.c presents results for DY1 through DY4 for Number of Critical Incidents by Reporting Category for the Self-Direction subcomponent. As illustrated, for DY4 the three the three categories with the largest number of critical incidents were Emergency Services, Abuse, and Death. As a proportion of total incidents, Emergency Services incidents increased by 9.7% while Death and Abuse incidents decreased by 26.7% and 14.3% respectively from DY3 to DY4.

Upon review of the individual MCO performance during the same reporting period, all MCOs experienced increases in the proportion of critical incidents for the largest category, Emergency Services, ranging from 2.5% to 15.1%.

A national average could not be identified for comparison to the DY4 Centennial Care rate.

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)[75]

Measure	Self-Direction - DY1		Self-Direction - DY2			Self-Direction - DY3			Self-Direction - DY4		
	# Members	Centennial Care Percent per Incident Type	# Members	Centennial Care Percent per Incident Type	DY1 - DY2 % Change	# Members	Centennial Care Percent per Incident	DY2 - DY3 % Change	# Members	Centennial Care Percent per Incident	DY3 - DY4 % Change
Abuse	69	8.3%	44	8.2%	-0.6%	78	11.4%	38.2%	99	9.8%	-14.3%
Death	93	11.2%	48	9.0%	-19.6%	58	8.5%	-5.8%	63	6.2%	-26.7%
Natural/Expected	83	89.2%	43	89.6%	0.4%	56	96.6%	7.8%	53	84.1%	-12.9%
Unexpected	10	10.8%	4	8.3%	-22.5%	2	3.4%	-58.6%	9	14.3%	314.3%
Homicide	0	0.0%	0	0.0%	0.0%	0	0.0%	0.0%	0	0.0%	0.0%
Suicide	0	0.0%	1	2.1%	NA	0	0.0%	-100.0%	1	1.6%	NA
Emergency Services	520	62.5%	354	66.3%	6.1%	452	66.0%	-0.5%	735	72.4%	9.7%
Environmental Hazard	12	1.4%	8	1.5%	3.9%	5	0.7%	-51.3%	6	0.6%	-19.0%
Exploitation	57	6.9%	34	6.4%	-7.1%	37	5.4%	-15.2%	33	3.3%	-39.8%
Law Enforcement	28	3.4%	24	4.5%	33.5%	18	2.6%	-41.5%	20	2.0%	-25.0%
Missing/Elopement	3	0.4%	7	1.3%	263.5%	1	0.1%	-88.9%	7	0.7%	372.4%
Neglect	50	6.0%	15	2.8%	-53.3%	36	5.3%	87.1%	52	5.1%	-2.5%
Total Number of Critical Incidents	**832**		**534**			**685**			**1,015**		

[75] Source: HSD/MAD Annual Report. Note that this source changed from MCO Critical Incident reports since the Interim Report to be consistent with final numbers published by HSD/MAD. Actual differences in numbers between sources are immaterial to results.

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.

Measure 50 – Antidepressant medication management.

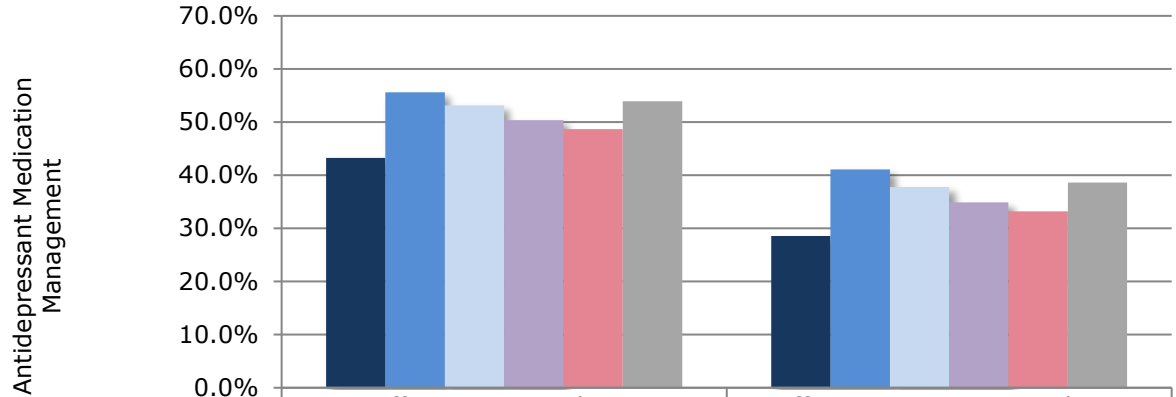
Exhibit 50 presents results for the 2013 baseline through DY4 and the 2017 HEDIS Medicaid national average for Antidepressant Medication Management. As illustrated, there was a decline in the effective acute phase treatment rate (-3.4%) and in the effective continuation phase treatment rate (-4.8%) from DY3 to DY4. Both declines were statistically significant at the 95% confidence level.

Upon review of the MCO's performance during the same reporting period, there were declines across all MCOs for both the acute and continuation phases.

Overall, the effective acute phase percentage increased 12.6% and the effective continuation phase increased 16.2% from the baseline to DY4, which were both statistically significant at the 95% confidence level.

Upon review of the MCO's performance during the same reporting period, all MCO's exhibited increases in both phases[76].

Exhibit 50 – Antidepressant Medication Management[77]



	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%
DY3 Centennial Care	50.4%	34.9%
DY4 Centennial Care	48.7%	33.2%
2017 National Avg	53.9%	38.6%

[76] Note that PHP did not report on this measure during the baseline period.

[77] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measure "amm").
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.

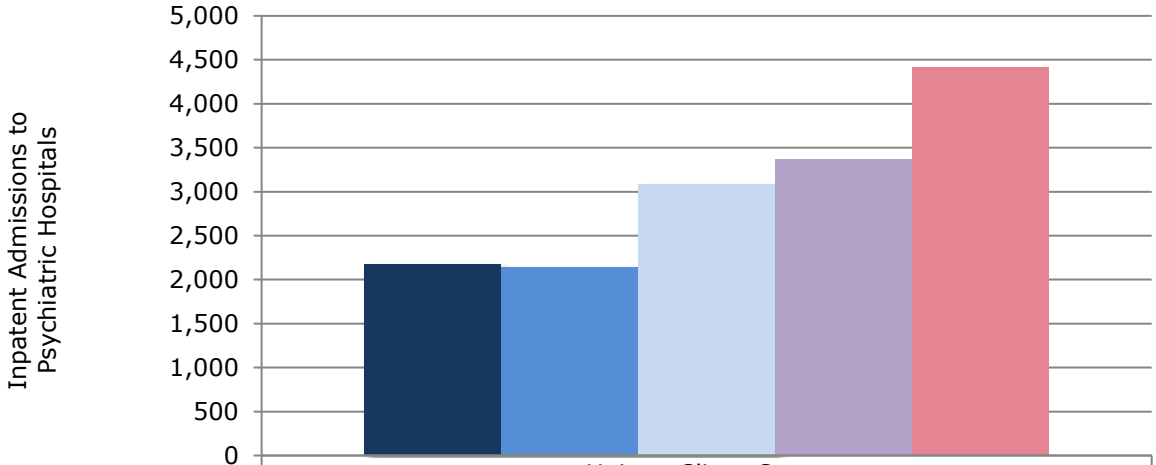
Measure 51 – Inpatient admissions to psychiatric hospitals and residential treatment centers.

Exhibit 51.a presents results for the 2013 baseline through DY4 for the Inpatient Admissions to Psychiatric Hospitals measure in aggregate. As illustrated, there was a 30.7% increase experienced in the number of inpatient admissions to psychiatric hospitals from DY3 to DY4. Similarly, the number of admissions increased 102.7% from the baseline to DY4. Through discussions with subject matter experts at Behavioral Health Services Division (BHSD), we learned that there was an increase in number of certain types of providers in the network that allowed for an access to needed services that may impacted the results of 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 51.a – Inpatient Admissions to Psychiatric Hospitals[78]



	Unique Client Count
2013 Baseline	2,177
DY1 Centennial Care	2,141
DY2 Centennial Care	3,086
DY3 Centennial Care	3,377
DY4 Centennial Care	4,413

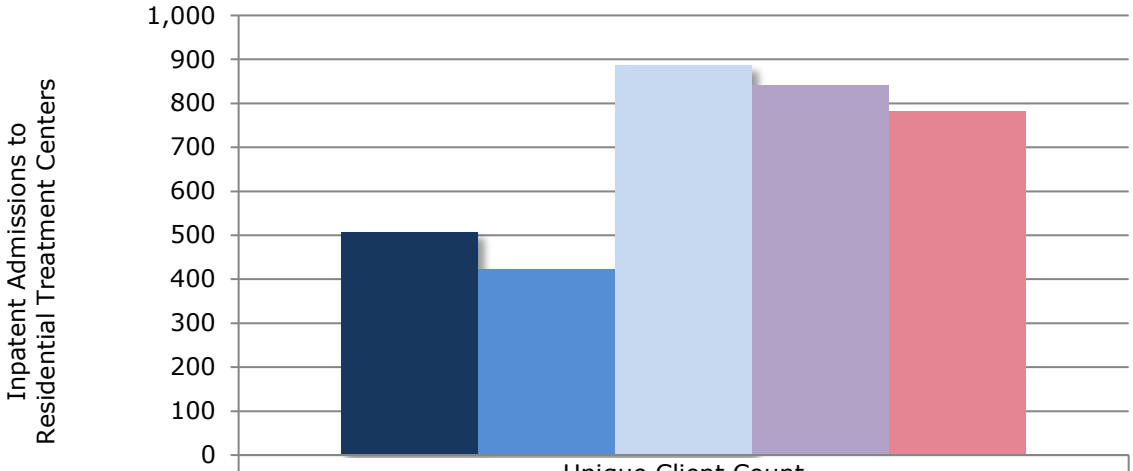
[78] Source: Admissions for Inpatient Psychiatric Hospitals and RTCs MMIS reports. Note that claims analysis criteria was revised between DY2 and DY3 to account for the ICD-9 changeover to ICD-10.
In the context of this report, discussions of changes in measure values between periods are based on the percent change (increase/decrease) which is calculated as [Current period measure value] / [Prior period measure value] – 1.

Exhibit 51.b presents results for the 2013 baseline through DY4 for the Inpatient Admissions to Residential Treatment Centers (RTCs). Note that RTCs treat Centennial Care's youth population through age 21. As illustrated, the percentage of inpatient admissions to RTCs decreased 13.7% from DY3 to DY4. In contrast, the percentage increased by 54.5% from the baseline to DY4. Despite this increase in the number of admissions, admission utilization per 1,000 decreased from the baseline to DY4 which is a positive outcome.

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.b – Inpatient Admissions to Residential Treatment Centers[79]



	Unique Client Count
2013 Baseline	506
DY1 Centennial Care	423
DY2 Centennial Care	886
DY3 Centennial Care	840
DY4 Centennial Care	782

[79] Source: Admissions for Inpatient Psychiatric Hospitals and RTCs MMIS reports. Note that data for DY2 was refreshed between Interim and Final reporting. In addition, claims analysis criteria was revised between DY2 and DY3 to account for the ICD-9 changeover to ICD-10.
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.

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 through DY4 for the Percentage of Nursing Facility Members Who Transitioned from a Low Nursing Facility to a High Nursing Facility. As illustrated, there was a slight decrease in the percentage of members who met low NF LOC (-0.5%) and an increase in the percentage of members who met high NF LOC (8.6%) from DY3 to DY4. These changes were statistically significant at the 95% confidence level.

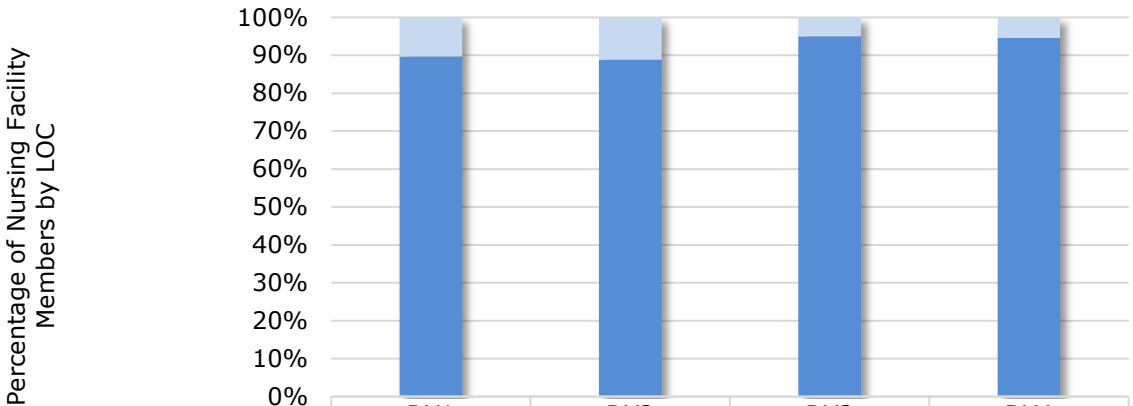
Upon review of the individual MCO performance during the same reporting period, the percentage of members who met low NF LOC increased for MHC (0.9%) and PHP (1.3%) and decreased for BCBS (-1.6%) and UHC (-0.2%).

The percentage of members who met low NF LOC increased 5.4% while the percentage of members who met high NF LOC decreased 47.2% from DY1 to DY4. These changes were statistically significant at the 95% confidence level.

Upon review of the individual MCO performance during the same reporting period, the percentage of members in low NF LOC increased for all MCOs with increases ranging from 1.3% to 17.4%.

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

Exhibit 52 – Percent of NF Residents by LOC[80]



	DY1 Centennial Care	DY2 Centennial Care	DY3 Centennial Care	DY4 Centennial Care
Percentage of Members who Meet High Nursing Facility Acuity	10.3%	11.2%	5.0%	5.4%
Percentage of Members who Meet Low Nursing Facility Acuity	89.7%	88.8%	95.0%	94.6%

[80] Source: MCO reports for 2014 – 2017 (HSD/MAD 8).
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.

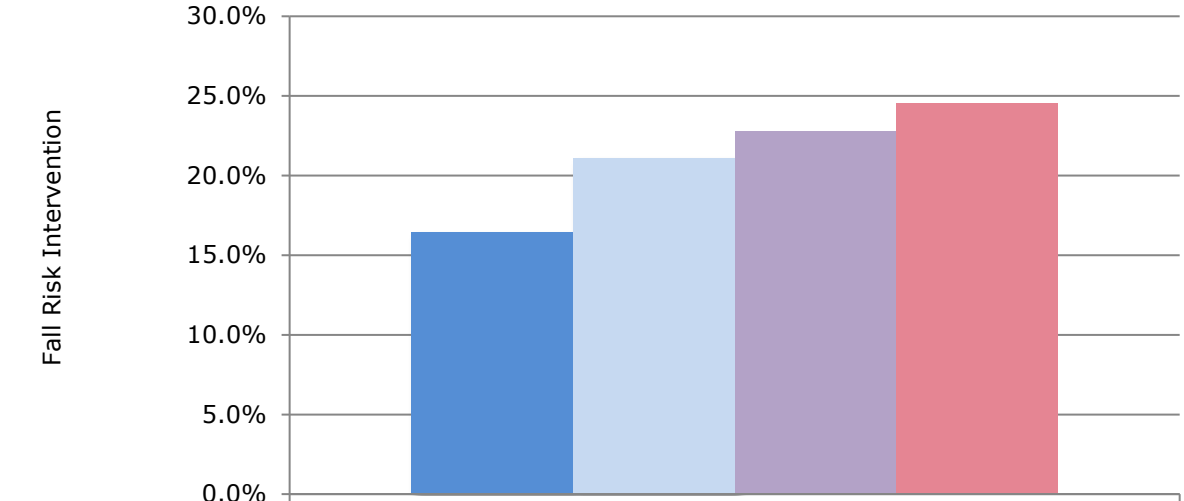
Measure 53 – Fall risk intervention.

Exhibit 53 presents rates for DY1 through DY4 for Fall Risk Intervention, which measures members 65 years of age and older who have had a fall or problem with balance in the last 12 months and who were seen by a provider and received a fall risk intervention.

As illustrated, the percentage of members that received a fall risk intervention increased 7.6% from DY3 to DY4, and increased by 49.3% from DY1 to DY4. Both increases were statistically significant at the 95% confidence level.

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

Exhibit 53 – Fall Risk Intervention[81]



	Fall Risk Management
DY1 Centennial Care	16.4%
DY2 Centennial Care	21.1%
DY3 Centennial Care	22.8%
DY4 Centennial Care	24.5%

[81] Source: NM HEDIS rates calculated by the State's actuary for 2014 – 2017. Note that DY3 information was updated since the Interim Report to reflect additional claims runout. The Interim Report incorporates two quarters of runout for DY3, this report incorporates four quarters of runout.
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.

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 reviewed 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 DY4 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 DY4. New Mexico saw increases in the percentage of members who had a BH service and received an LTSS service, increases in the percentage of members who had a BH service and utilized HCBS, favorable declines in the percentage of members with BH needs who had an ER visit, and relatively favorable experience related to transitions between care coordination levels.

The percentage of members who had a BH service and received an outpatient ambulatory visit in the same year remained relatively consistent over the course of Centennial Care.

Potential opportunities for improvement were identified for 5 out of 11 measures. The percentage of members accessing both a BH service and a PCP visit in the same year declined, as did the percentage of members accessing both a LTSS service and a PCP visit in the same year. Diabetes screening for members with schizophrenia or bipolar disorder who are using antipsychotic medications also declined, as did diabetes monitoring for people with diabetes and schizophrenia. There was also an unfavorable increase in the percentage of members with LTSS needs who had an ER visit.

The measure for the percentage of members at risk for NF placement who remained in the community was retired after DY2 as members are no longer required to enter a NF as the only means of receiving NF LOC services, and thus the measure was no longer valid. However, the data through DY2 that was included in the Interim is provided for reference.

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

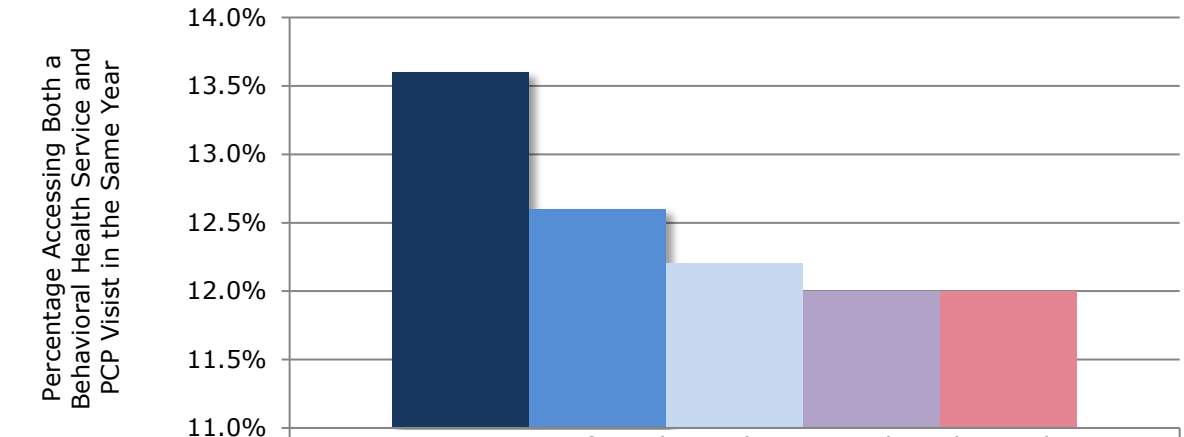
Exhibit 54 presents results for the 2013 baseline through DY4 for the Percentage of the Population Accessing a Behavioral Health Service and a PCP Visit in the Same Year. As illustrated, the percentage of members that accessed both a BH service and PCP visit in the same year remained consistent at 12.0% from DY3 to DY4.

Upon review of the individual MCO performance over the same reporting period, UHC and BCBS experienced a decline in percentage of 0.2% and 0.5% respectively. MHC and PHP both experienced increases in percentage of 1.1% and 0.6% respectively.

There was a 11.8% decline in the percentage of members utilizing both a BH service and PCP visit in the same year from baseline to DY4. 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[82]



	Percentage of Members Who Accessed a Behavioral Health Service and PCP Visit in the Same Year
2013 Baseline	13.6%
DY1 Centennial Care	12.6%
DY2 Centennial Care	12.2%
DY3 Centennial Care	12.0%
DY4 Centennial Care	12.0%

[82] Source: BH and PCP Visits MMIS reports for 2013 – 2017. Note that claims analysis criteria was revised between DY2 and DY3 to account for the ICD-9 changeover to ICD-10.
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.

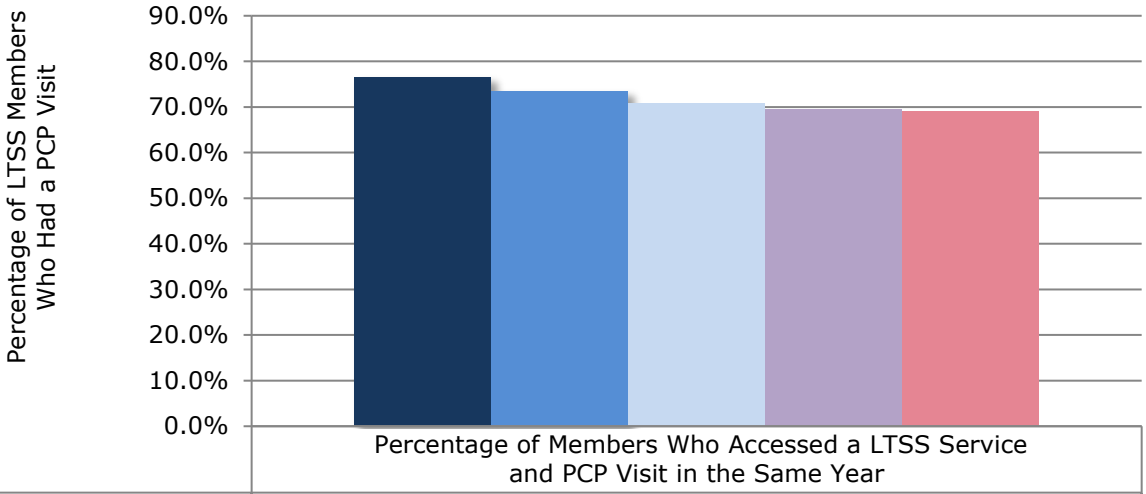
Measure 55 – Percentage of the LTSS population that received a PCP visit in the year (Percentage of population accessing an LTSS service that received a PCP visit in the same year).

Exhibit 55 presents results for the 2013 baseline through DY4 for the Percentage of the LTSS Population that Received a PCP Visit in the Same Year. As illustrated, the percentage of members with a PCP visit in the same year experienced a small decrease of 0.4% from DY3 to DY4.

Similarly, the percentage of LTSS members with a PCP visit in the same year experienced a decrease of 9.7% from the baseline to DY4. This change was statistically significant at a 95% confidence level.

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

Exhibit 55 – Percentage of the LTSS Population That Received a PCP Visit in Same Year[83]



	Percentage of Members Who Accessed a LTSS Service and PCP Visit in the Same Year
2013 Baseline	76.5%
DY1 Centennial Care	73.5%
DY2 Centennial Care	70.7%
DY3 Centennial Care	69.4%
DY4 Centennial Care	69.1%

[83] Source: LTSS and PCP Visits MMIS reports for 2013 – 2017. Note that claims analysis criteria was revised between DY2 and DY3 to account for the ICD-9 changeover to ICD-10.
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.

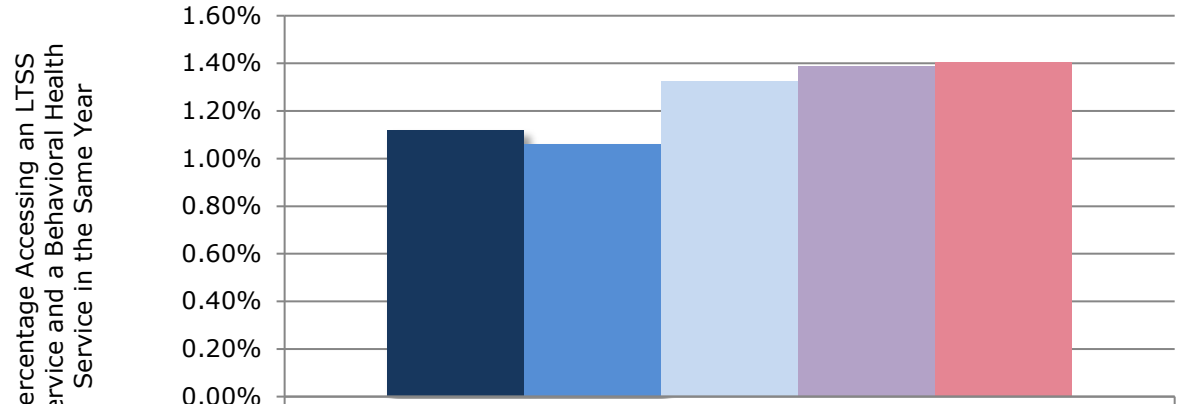
Measure 56 – Percentage of the population accessing an LTSS service and a behavioral health visit in the same year.

Exhibit 56 below presents results for the 2013 baseline through DY4 for the measure Percentage of Participants Who Accessed an LTSS Service and a Behavioral Health Visit in the Same Year. As illustrated, there was a 1.11% increase in the percentage of members accessing both LTSS and a BH service from DY3 to DY4.

Similarly, the percentage of participants accessing both an LTSS service and BH service in the same year increased 25.57% from the baseline to DY4. 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[84]



	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%
DY4 Centennial Care	1.40%

[84] Source: LTSS and BH MMIS reports for 2013 – 2017. Note that claims analysis criteria was revised between DY2 and DY3 to account for the ICD-9 changeover to ICD-10.
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.

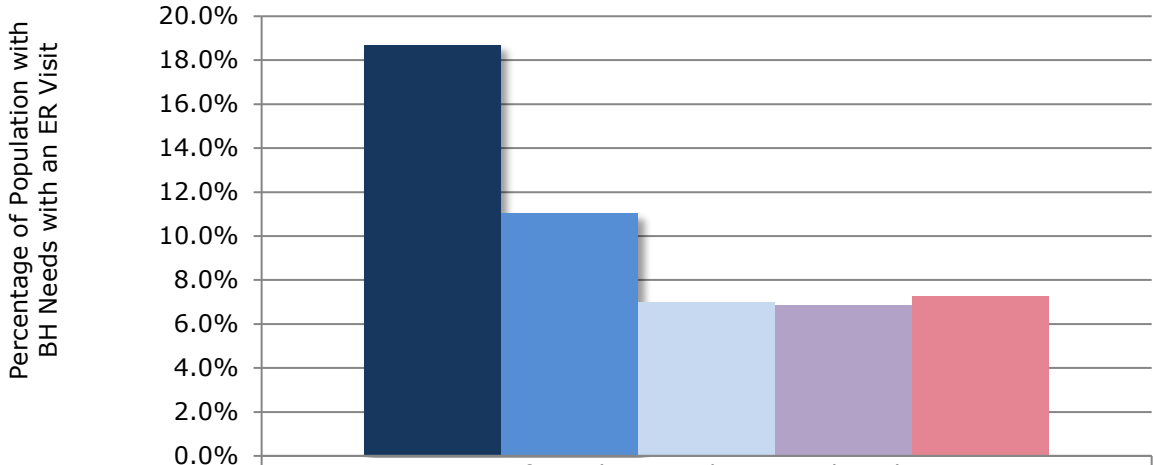
Measure 57 – Percentage of population with behavioral health needs with an ER visit by type of ER visit.

Exhibit 57.a presents results for the 2013 baseline through DY4 for the measure Percentage of the Population with Behavioral Health Needs with an ER Visit. As illustrated, there was a 5.9% increase in the total percentage of members with ER visits from DY3 to DY4. This increase was a statistically significant change at a 95% confidence level.

In contrast, there was a favorable decline in the percentage of BH members with an ER visit of 61.2% from the baseline to DY4. This decrease was a statistically significant change at a 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[85]



	Percentage of Population with BH Needs with an ER Visit
2013 Baseline	18.7%
DY1 Centennial Care	11.0%
DY2 Centennial Care	7.0%
DY3 Centennial Care	6.9%
DY4 Centennial Care	7.3%

[85] Source: BH population with ED visits MMIS reports for 2013 – 2017. Note that data for DY2 was refreshed between Interim and Final reporting. In addition, claims analysis criteria was revised between DY2 and DY3 to account for the ICD-9 changeover to ICD-10.
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.

Exhibit 57.b presents results for the 2013 baseline through DY4 for the measure Percentage of the Population with BH Needs with an ER Visit by Type of ER Visit. Overall each of the subcomponents were under 3.0% in DY4, a positive outcome. As illustrated, there were favorable declines in three (Limited to Moderate, Low to Moderate, and High Severity) of the eight ER visit types from DY3 to DY4 with a range of 0.36% to 22.59% in changes. Declines for Limited to Moderate and Low to Moderate were statistically significant at the 95% confidence level.

There were unfavorable increases in four of the eight ER visit types from DY3 to DY4, namely Emergency Medical Treatment and Labor Act (EMTALA), Moderate, Life Threatening, and Admitted through the ER. All changes except for the increase for the Admitted through the ER subcomponent were statistically significant at the 95% confidence level.

There were favorable declines in all percentages from the baseline to DY4 except in the EMTALA category which experienced a 260.22% increase, however the actual percentage in DY4 was less than 1.0%. The largest decline among the other subcomponents was in urgent care visits (-95.97% change). The smallest decline was in limited to minor type ER visits (-48.24% change). All changes from the baseline to DY4 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[86]

ER Visit Type	2013 Baseline	DY1 Centennial Care	DY2 Centennial Care	DY3 Centennial Care	DY4 Centennial Care
EMTALA	0.23%	0.09%	0.08%	0.06%	0.83%
Urgent Care	0.02%	0.00%	0.00%	0.00%	0.00%
Limited or Minor	0.59%	0.32%	0.37%	0.38%	0.31%
Low to Moderate	1.77%	0.59%	0.73%	0.62%	0.48%
Moderate	6.41%	2.49%	2.21%	2.23%	2.33%
High Severity	7.00%	2.24%	2.52%	2.57%	2.56%
Life Threatening	5.39%	2.47%	2.29%	2.15%	2.70%
Admitted through the ER	3.57%	5.14%	0.89%	0.99%	1.04%

[86] Source: BH population with ED visits MMIS reports for 2013 – 2017. Note that claims analysis criteria was revised between DY2 and DY3 to account for the ICD-9 changeover to ICD-10.
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.

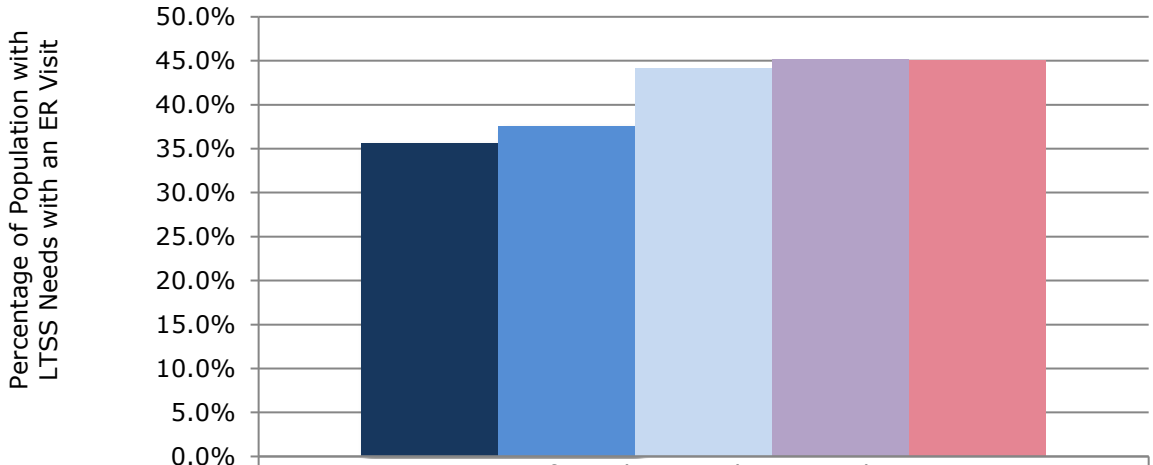
Measure 58 – Percentage of population with LTSS needs with an ER visit by type of ER visit.

Exhibit 58.a below presents rates for the 2013 baseline through DY4 for the measure Percentage of the Population with LTSS Needs with an ER Visit. As illustrated, there was a favorable 0.2% decrease in the total percentage of LTSS members with an ER visit from DY3 to DY4.

In contrast, there was an unfavorable increase experienced in the total percentage at 26.2% from baseline to DY4. This was a statistically significant change 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[87]



	Percentage of Population with LTSS with an ER Visit
2013 Baseline	35.7%
DY1 Centennial Care	37.6%
DY2 Centennial Care	44.2%
DY3 Centennial Care	45.2%
DY4 Centennial Care	45.1%

[87] Source: LTSS Population with ED visits MMIS reports for 2013 – 2017. Note that claims analysis criteria was revised between DY2 and DY3 to account for the ICD-9 changeover to ICD-10.
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.

Exhibit 58.b presents rates for the 2013 baseline through DY4 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 six (Urgent Care, Limited to Minor, Low to Moderate, Moderate, High Severity, and Admitted through the ER) of the eight ER visit types from DY3 to DY4 with decreases ranging from 0.69% to 17.58%.

There was an unfavorable increase in the reported rate for EMTALA and Life Threatening ER visit types from DY3 to DY4 with increases of 182.24% and 8.62% respectively. Note that the actual percentage of the LTSS population with an EMTALA visit was under 1.0% for DY4.

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

Low to Moderate experienced a favorable decline of 3.59% from the baseline to DY4, while the other subcomponents experienced increases ranging from 27.34% to 109.23%. All changes were statistically significant at the 95% confidence level.

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[88]

ER Visit Type	BL	DY1	DY2	DY3	DY4
EMTALA	0.30%	0.25%	0.29%	0.22%	0.62%
Urgent Care	0.02%	0.02%	0.01%	0.01%	0.01%
Limited or Minor	1.50%	1.76%	2.68%	2.68%	2.24%
Low to Moderate	3.91%	3.73%	4.88%	4.57%	3.77%
Moderate	13.33%	13.78%	16.06%	17.34%	16.97%
High Severity	15.18%	15.46%	19.67%	20.89%	20.75%
Life Threatening	13.19%	14.07%	17.22%	18.09%	19.65%
Admitted through the ER	8.66%	12.78%	14.47%	13.93%	13.32%

[88] Source: LTSS Population with ED visits MMIS reports for 2013 – 2017. Note that claims analysis criteria was revised between DY2 and DY3 to account for the ICD-9 changeover to ICD-10.
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.

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).

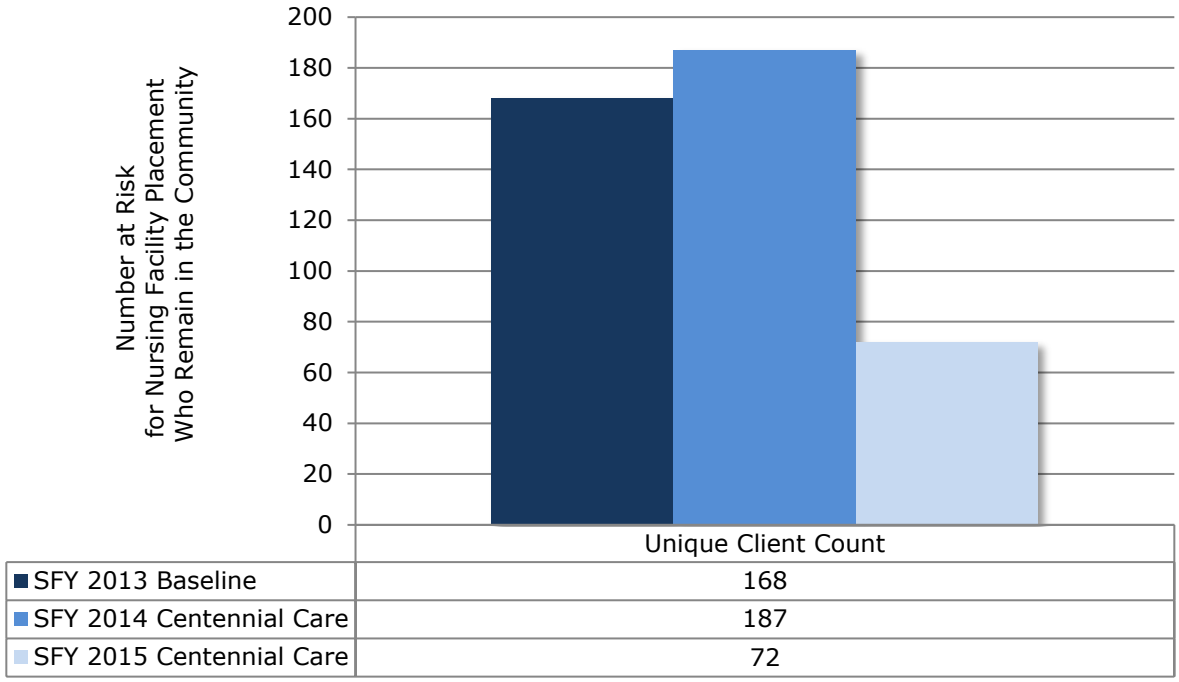
Exhibit 59 presents results for the 2013 baseline, DY1, and DY2 for the Number at Risk for Nursing Facility Placement Who Remain in the Community. As illustrated, the number of members that transitioned from NFs into the community declined 61.5% from DY1 to DY2. Similarly, the rate also declined (57.1%) 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, data collection and analysis for this measure ceased after DY2. Therefore, this measure is no longer valid.

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[89]



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

[89] Source: NM Medical Assistance Division (MAD) reports. Note that this measure was retired after DY2 and thus the analysis above is consistent with results presented in the Interim Report.
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.

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

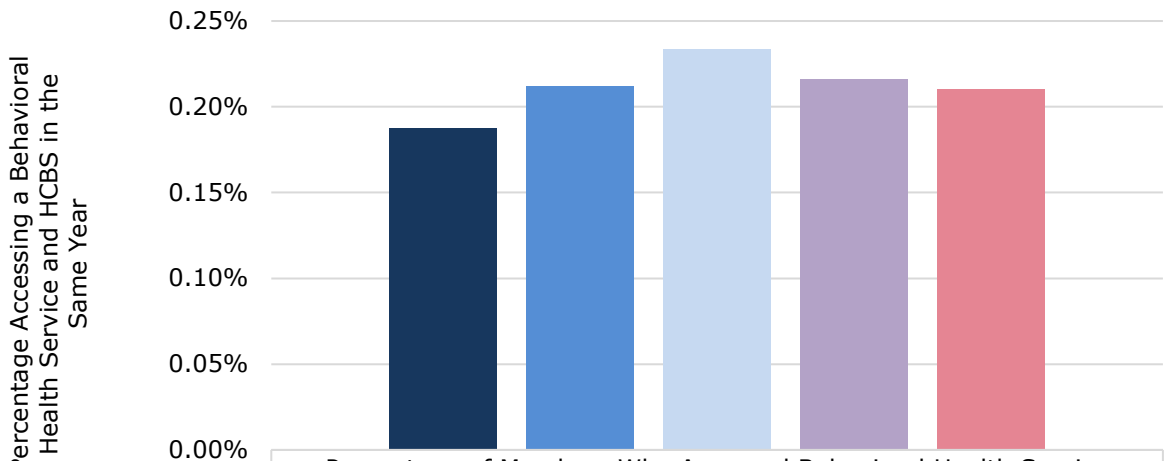
Exhibits 60.a and 60.b below present results for the 2013 baseline through DY4 for the Percentage and Number of Members who Accessed a Behavioral Health Service that also Accessed HCBS in the Same Year. As illustrated, there was a slight 2.7% decrease in the percentage of members accessing both BH and HCBS services from DY3 to DY4, which was not a statistically significant change at a 95% confidence level.

Upon review of the individual MCOs during the same reporting period, BCBS was the only MCO to experience an increase (4.1%) while MHC, PHP, and UHC experienced decreases of 4.5%, 3.0%, and 9.6% respectively.

The percentage of members who accessed a behavioral health service and HCBS in the same year increased by 12.2% from baseline to DY4, which was statistically significant at a 95% confidence level.

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

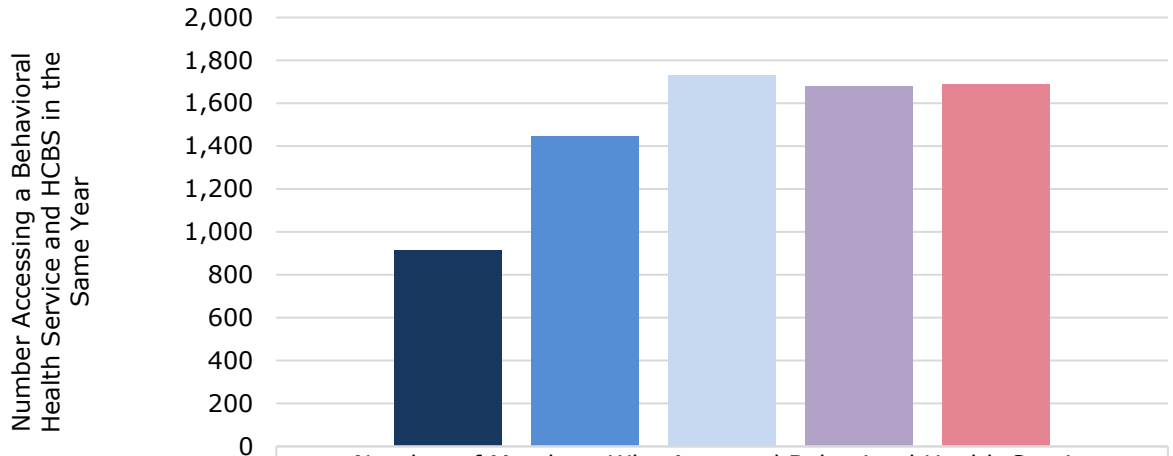
Exhibit 60.a – Percentage of Members Who Accessed a Behavioral Health Service and That Also Accessed HCBS in the Same Year[90]



	Percentage of Members Who Accessed Behavioral Health Service and HCBS
2013 Baseline	0.19%
DY1 Centennial Care	0.21%
DY2 Centennial Care	0.23%
DY3 Centennial Care	0.22%
DY3 Centennial Care	0.21%

[90] Source: BH Population with HCBS MMIS reports for 2013 – 2017. Note that claims analysis criteria was revised between DY2 and DY3 to account for the ICD-9 changeover to ICD-10.
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.

Exhibit 60.b – Number of Members Who Accessed a Behavioral Health Service and That Also Accessed HCBS in the Same Year[91]



	Number of Members Who Accessed Behavioral Health Service and HCBS
2013 Baseline	916
DY1 Centennial Care	1,446
DY2 Centennial Care	1,733
DY3 Centennial Care	1,681
DY3 Centennial Care	1,688

[91] Source: BH Population with HCBS MMIS reports for 2013 – 2017. Note that claims analysis criteria was revised between DY2 and DY3 to account for the ICD-9 changeover to ICD-10.
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.

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.

Exhibits 61.a and 61.b present results for DY1 through DY4 for the percentage and number 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 decrease (-14.2%) in the average number of members that maintained their care coordination from DY3 to DY4. The percentage of members that maintained their care coordination level compared to the total members receiving care coordination decreased from 96.1% to 94.8%. However, it is important to emphasize that in DY4:

- The number of members who maintained care coordination level decreased by 8,016 members from 56,358 members in DY3 to 48,342 members in DY4.
- The total number of members with care coordination also decreased by 7,701 members (lower than the decrease in number of members who maintained care coordination) from 58,671 members in DY3 to 50,970 members in DY4.

In other words, in DY4, the reduction in the number of members who maintained their care coordination level in DY4 was more than the reduction in the total number of members needing care coordination. This can be a favorable outcome, considering that in DY4, the increase in member enrollment has slowed down to a 1% increase from DY3 (see Measure 7). Simply put, the fact that the total number of members with care coordination decreased may be more important than the number of members maintaining care coordination level, especially when there were only 244 members who moved to higher care coordination level.

There was an increase (8.0%) in the average number of members that moved to a lower care coordination level from DY3 to DY4. The percentage of members that moved to a lower care coordination level compared to the average total number of members receiving care coordination increased from 1.5% to 1.9% from DY3 to DY4, a favorable outcome.

There was an increase (17.2%) in the average number of members that moved to a higher care coordination level from DY3 to DY4. The percentage of members that moved to a higher care coordination level compared to the average total number of members receiving care coordination increased from 2.4% to 3.3% from DY3 to DY4.

Although DY4's shift pattern between care coordination levels compared to DY3 was generally unfavorable in the sense of a lower percentage of members maintained their care coordination level and a higher percentage moved to a higher level, the favorable outcome is that the overall number of members in need of care coordination decreased and a greater percentage of members moved to a lower care coordination level. Members moving to a lower care coordination level also contributed to the lower percentage of members that maintained their care coordination level.

As illustrated, there was an increase (45.6%) in the average number of members that maintained their care coordination from DY1 to DY4. The percentage of members that maintained their care coordination level compared to the total members receiving care coordination increased from 92.2% to 94.8%.

There was an increase (158.0%) in the average number of members that moved to a lower care coordination level from DY1 to DY4. The percentage of members that moved to a lower care coordination level compared to the total number of members receiving care coordination increased from 1.0% to 1.9%.

There was a decrease (-31.7%) in the average number of members that moved to a higher care coordination level from DY1 to DY4. The percentage of members that moved to a higher care

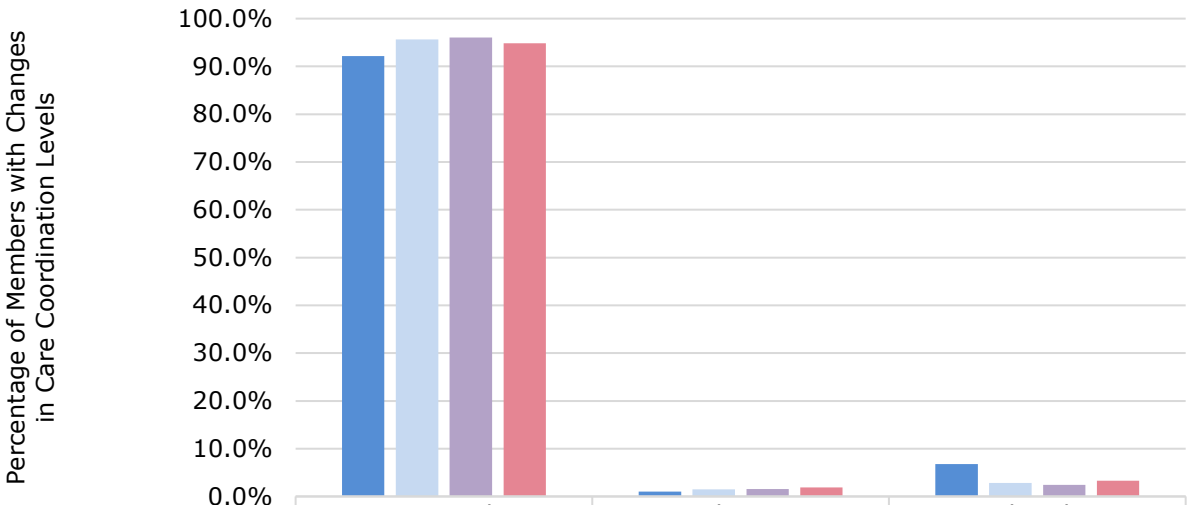
coordination level compared to the total number of members receiving care coordination decreased from 6.8% to 3.3%.

All of the shifts that occurred over the scope of Centennial Care from DY1 to DY4 were positive, as the shift pattern indicated higher stability in care coordination levels for complex members, and general shifting from higher to lower care coordination levels as member care plans developed.

A national average could not be identified for this measure.

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

Exhibit 61.a – Percentage Changes in Care Coordination Levels[92]

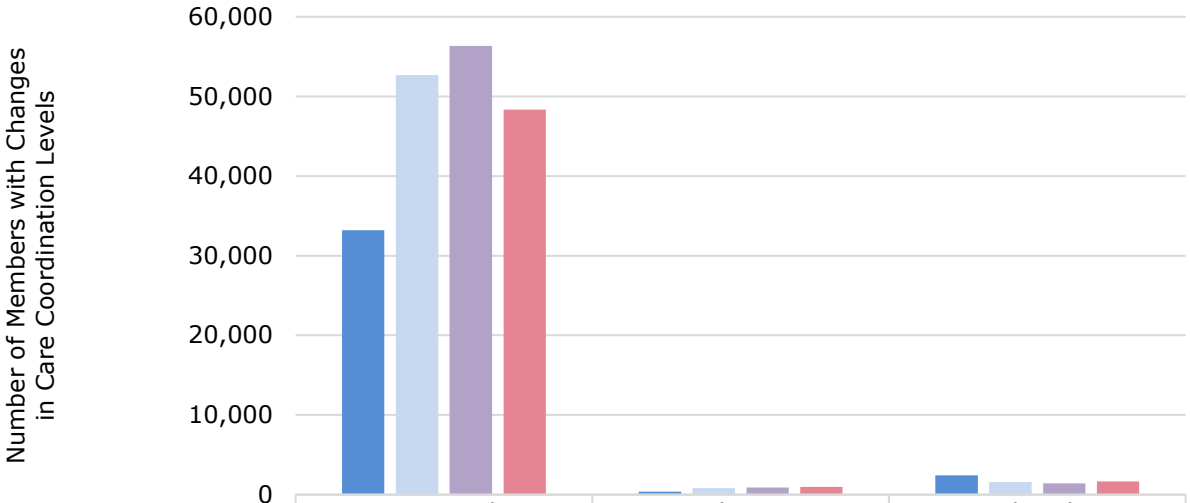


	Maintained %	Moved Lower %	Moved Higher %
DY1 Centennial Care	92.2%	1.0%	6.8%
DY2 Centennial Care	95.7%	1.5%	2.8%
DY3 Centennial Care	96.1%	1.5%	2.4%
DY4 Centennial Care	94.8%	1.9%	3.3%

[92] Source: MCO ad hoc care coordination reports for 2014 – 2017.

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.

Exhibit 61.b – Number of Members by Care Coordination Level Transitions[93]



	Maintained #	Moved Lower #	Moved Higher #
DY1 Centennial Care	33,195	373	2,438
DY2 Centennial Care	52,701	829	1,564
DY3 Centennial Care	56,358	891	1,422
DY4 Centennial Care	48,342	962	1,666

[93] Source: MCO ad hoc care coordination reports for 2014 – 2017.

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.

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

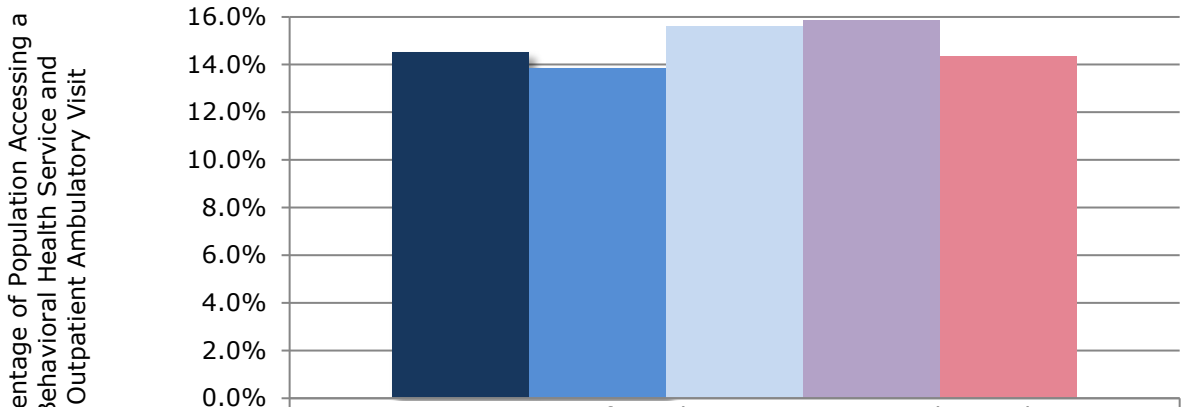
Exhibit 62 presents results for the 2013 baseline through DY4 for the Percentage of the Population Accessing a Behavioral Health Service that Received an Outpatient Ambulatory Visit in the Same Year. As illustrated, the percentage of members utilizing both a BH service and outpatient ambulatory visit in the same year decreased 9.5% from DY3 to DY4. This change was statistically significant at the 95% confidence level.

Upon review of the individual MCO performance over the same reporting period, there were decreases in the percentage of members accessing a BH service that received an outpatient ambulatory visit in the same year for BCBS (-9.0%), MHC (-10.4%), PHP (-8.4%), and UHC (-11.4%).

When analyzing the baseline to DY4 performance trend, the percentage of members utilizing both a BH service and outpatient ambulatory visit in the same year experienced a marginal decrease of 1.0%. This change was statistically significant at the 95% confidence level.

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[94]



	Percentage of Population Accessing a Behavioral Health Service that Received an Outpatient Ambulatory Visit in the Same Year
2013 Baseline	14.5%
DY1 Centennial Care	13.9%
DY2 Centennial Care	15.6%
DY3 Centennial Care	15.9%
DY4 Centennial Care	14.4%

[94] Source: BH Clients with Outpatient Ambulatory Visits MMIS reports for 2013 – 2017. Note that claims analysis criteria was revised between DY2 and DY3 to account for the ICD-9 changeover to ICD-10.
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.

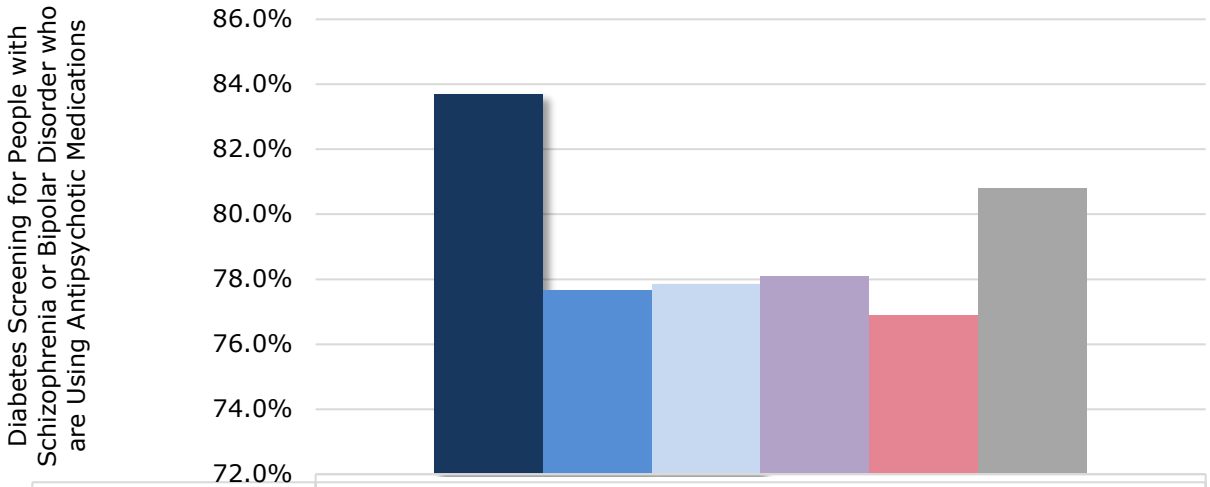
Measure 63 – Diabetes screening for members with schizophrenia or bipolar disorder who are using antipsychotic medications.

Exhibit 63 presents rates for the 2013 baseline through DY4 and the 2017 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 decrease of 1.5% in the percentage from DY3 to DY4, but the change was not statistically significant at the 95% confidence level.

The rate declined from the baseline to DY4 by 8.1%, which was statistically significant at the 95% confidence level. Upon review of the individual MCO performance during the same reporting period, PHP experienced the largest decrease at 10.4% which was statistically significant at the 95% confidence level. MHC and UHC experienced declines of 3.0% and 5.3% respectively from the baseline to DY4. BCBS did not have a reportable rate in the 2013 baseline but experienced a 2.6% decline from DY1 to DY4.

DY4 results were also below the 2017 HEDIS Medicaid national average.

Exhibit 63 – Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication[95]



2013 Baseline	83.7%
DY1 Centennial Care	77.6%
DY2 Centennial Care	77.9%
DY3 Centennial Care	78.1%
DY4 Centennial Care	76.9%
2017 National Avg	80.8%

[95] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measure "ssd").
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.

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

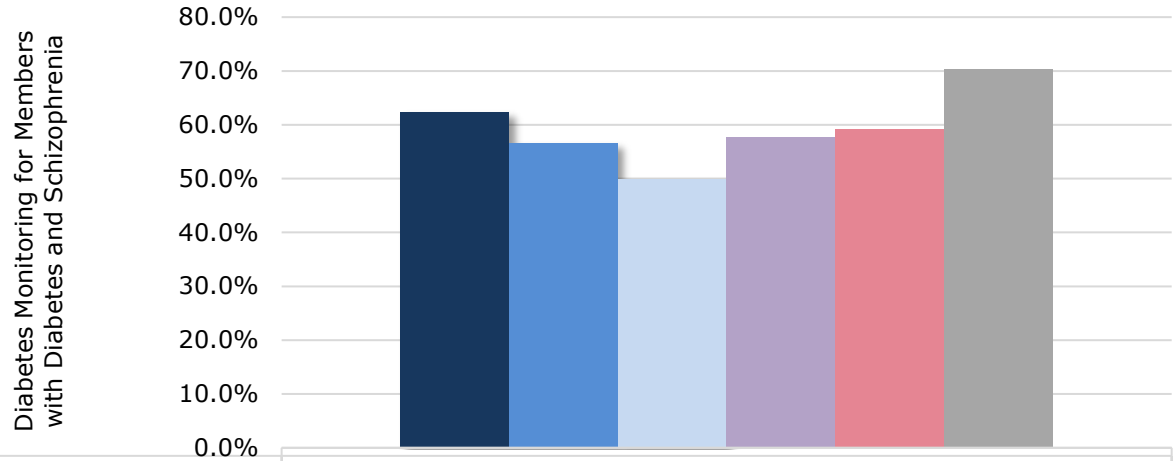
Exhibit 64 presents rates for the 2013 baseline through DY4 and the 2017 HEDIS Medicaid national average for the measure Diabetes Monitoring for People with Diabetes and Schizophrenia. As illustrated, there was an increase in the percentage from DY3 to DY4 of 2.8%, which was not statistically significant at the 95% confidence level.

Upon review of the individual MCO performance during the same reporting period, MHC, UHC, and PHP experienced percentage increases of 10.8%, 9.3%, and 1.2% respectively. BCBS experienced a 13.8% decline from DY3 to DY4.

The aggregate percentage decreased by 5.0% from the baseline to DY4, which was not statistically significant at the 95% confidence level. For the two plans for which there was sufficient data to calculate rates for both reporting periods, PHP declined 16.5% while UHC increased by 11.5%.

Despite an aggregate decline for these two plans from the baseline to DY4, it is important to note the positive trend from DY1 to DY4 once all plans began consistently reporting on this measure, and the aggregate percentage increased by 4.6% over this period.

Exhibit 64 – Diabetes Monitoring for Members with Diabetes and Schizophrenia[96]



2013 Baseline	62.4%
DY1 Centennial Care	56.6%
DY2 Centennial Care	49.9%
DY3 Centennial Care	57.6%
DY4 Centennial Care	59.2%
2017 National Avg	70.4%

[96] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measure "smd").
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.

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 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 PH and BH 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 DY4, and based on discussions with the State, more acute and higher cost individuals enrolled in DY1 and fewer acute enrolled in later demonstration years, although this trend is changing in DY4. These enrollment changes in the Other Adult Group 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/MAD 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)
- Patent loss on Abilify (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 reviewed 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 DY4 of the program, costs continue to be budget neutral and utilization is shifting away from more costly services. There were clear improvements in nine of 15 performance measures and their subcomponents, with four other measures showing both positive and negative results, depending on the subcomponent, and four showing a decline.

New Mexico saw improvement from the baseline to DY4 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 improvements 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 mental health/substance abuse services improved and services exceeding $50,000 experienced a favorable decline.

There were mixed results for two out of 15 measures. 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 NF LOC use while lower NF LOC 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 DY4. The use of institutional care also experienced increases in days per thousand but decreases in admits per thousand.

There was a slight decline in performance from the baseline to DY4 for diagnostic imaging costs (however these costs remain very immaterial) and hospital costs. There were also declines in performance for ED use and all cause readmissions, both of which experienced unfavorable increases.

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 through DY4 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 each demonstration year (DY1 through DY4) were below cost projections for all MEGs apart from the NF LOC Dual group[97]. Total DY4 costs as of February 7, 2018 were 28.1% below the STC cost projections for DY4. In addition, the total expenditures for DY4 decreased compared to DY3 despite an increase in membership, which is a positive outcome.

The Group VIII (Medicaid-expansion eligible adults) and Temporary Assistance for Needy Families (TANF) groups experienced the greatest dollar difference between projected costs and actual costs in DY4; the Group VIII actual costs were approximately $686M below projected costs (or 32.6%) and TANF actual costs were approximately $565M below projected costs (or 28.3%). The SSI-Dual group also experienced material differences between projected and actual costs in DY4, where actual costs were approximately $334M below projected costs (or 37.7%) 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 DY4. The reportable data from CMS-64 Schedule C and the Budget Neutrality tables submitted to CMS indicate relatively lower costs for the NF LOC population. In addition, with less than 4,500 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.

For the NF LOC Dual group, HSD/MAD 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.

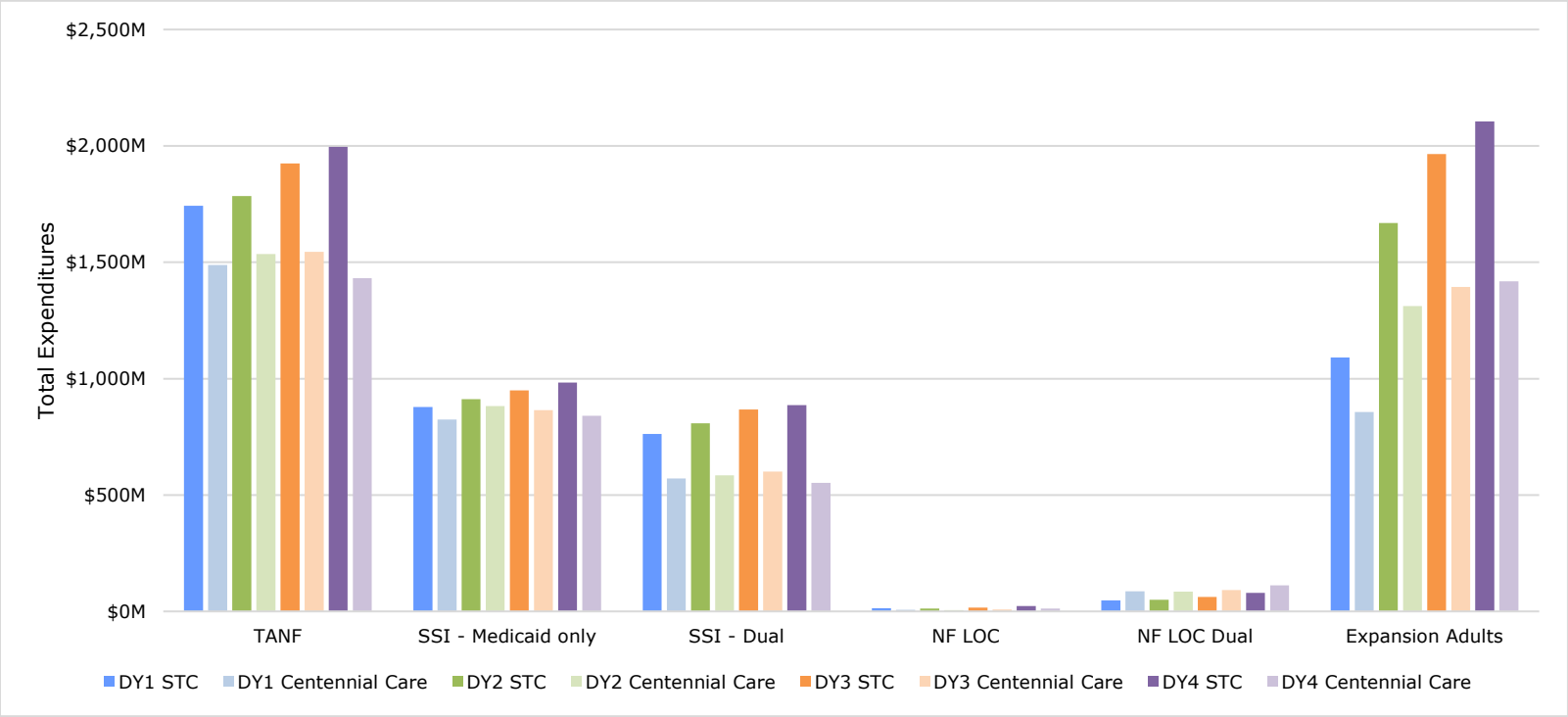
The footnote of Exhibit 65.b below specifies that the cost comparison for TANF members does not include the costs and member months for children living in families with incomes between 133% and 185% of the federal poverty level as those costs and member months were reported under CHIP. Expenses reported 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.

[97] 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 DY4 Total Program Expenditures by MEG[98]



[98] Source: Budget Neutrality tables, sourced from New Mexico Budget Neutrality Monitoring Spreadsheet, Attachment A, Quarter End December 2017.

Exhibit 65.b – DY1 to DY4 Total Program Expenditures by MEG[99]

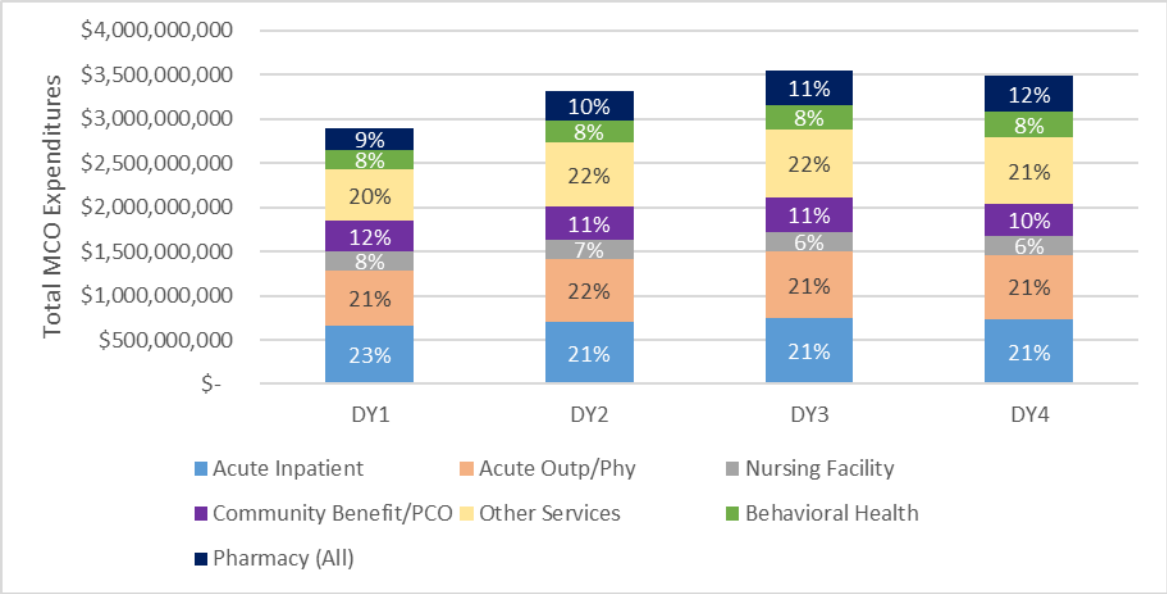
Year and Measure		TANF	SSI - Medicaid only	SSI - Dual	NF LOC	NF LOC Dual	Expansion Adults	Uncompensated Care	HQII	Total
2014	STC	$1,742,716,084	$878,348,116	$762,214,079	$13,818,439	$47,789,726	$1,090,861,379	$68,889,322	$0	**$4,604,637,146**
	Centennial Care	$1,488,754,304	$824,638,553	$570,612,226	$6,662,084	$86,786,741	$857,043,080	$68,889,323	$0	**$3,903,386,311**
	Measured Over/ (Under)	($253,961,780)	($53,709,563)	($191,601,853)	($7,156,355)	$38,997,016	($233,818,299)	$1	$0	**($701,250,835)**
	% Measured Over / (Under)	-14.6%	-6.1%	-25.1%	-51.8%	81.6%	-21.4%	0.0%	0.0%	**-15.2%**
2015	STC	$1,785,145,803	$911,332,877	$808,202,928	$12,125,476	$50,156,129	$1,669,354,159	$68,889,322	$2,824,462	**$5,308,031,155**
	Centennial Care	$1,535,080,277	$882,372,838	$584,167,632	$5,554,385	$85,077,407	$1,311,689,926	$67,294,973	$2,824,462	**$4,474,061,900**
	Measured Over/ (Under)	($250,065,526)	($28,960,039)	($224,035,296)	($6,571,091)	$34,921,278	($357,664,233)	($1,594,349)	$0	**($833,969,255)**
	% Measured Over / (Under)	-14.0%	-3.2%	-27.7%	-54.2%	69.6%	-21.4%	-2.3%	0.0%	**-15.7%**
2016	STC	$1,924,087,826	$950,239,376	$867,484,575	$15,678,076	$61,596,978	$1,964,765,415	$68,889,322	$7,359,077	**$5,860,100,645**
	Centennial Care	$1,544,356,199	$865,090,623	$600,142,952	$7,590,384	$91,598,699	$1,393,608,289	$68,889,323	$7,359,077	**$4,578,635,546**
	Measured Over/ (Under)	($379,731,627)	($85,148,753)	($267,341,623)	($8,087,692)	$30,001,721	($571,157,126)	$1	$0	**($1,281,465,099)**
	% Measured Over / (Under)	-19.7%	-9.0%	-30.8%	-51.6%	48.7%	-29.1%	0.0%	0.0%	**-21.9%**
2017	STC	$1,996,001,712	$983,275,432	$886,165,378	$23,093,047	$79,985,529	$2,104,671,477	$68,889,322	$0	**$6,142,081,897**
	Centennial Care	$1,431,162,319	$839,861,416	$552,047,932	$12,410,795	$111,430,661	$1,418,096,328	$51,666,993	$0	**$4,416,676,444**
	Measured Over/ (Under)	($564,839,393)	($143,414,016)	($334,117,446)	($10,682,252)	$31,445,132	($686,575,149)	($17,222,329)	$0	**($1,725,405,453)**
	% Measured Over / (Under)	-28.3%	-14.6%	-37.7%	-46.3%	39.3%	-32.6%	-25.0%	0.0%	**-28.1%**

[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.

[99] Source: Budget Neutrality tables, sourced from New Mexico Budget Neutrality Monitoring Spreadsheet, Attachment A, Quarter End December 2017. The 2017 uncompensated care payment consists of three quarters of payments; one quarter of payments have not been made as of December 31, 2017.
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.

The Evaluation also examined data summarized by the State's actuary which presents the distribution of total program expenditures by service category in DY1 through DY4. As Exhibit 65.b illustrates, the distribution of program expenditure has been relatively stable throughout DY1 to DY4. Notable trends from DY1 to DY4 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. It should also be noted that total MCO expenditures have decreased slightly from DY3 to DY4, while membership continued to experience slight increases.

Exhibit 65.b – DY1 to DY4 Total Program Expenditure Distribution by Service Category[100]



[100] Source: Data summarized by the State's actuary based on financial statements submitted by MCOs. MCO expenditures are not the same as Centennial Care total program expenditures (which include program administrative expenses and other allowable expenses), though cost distribution across categories of service would generally align.

Measure 66 – Costs per member.

Exhibit 66.a presents the annual cost per member for DY1 through DY4 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 DY4 apart from the NF LOC Dual group.

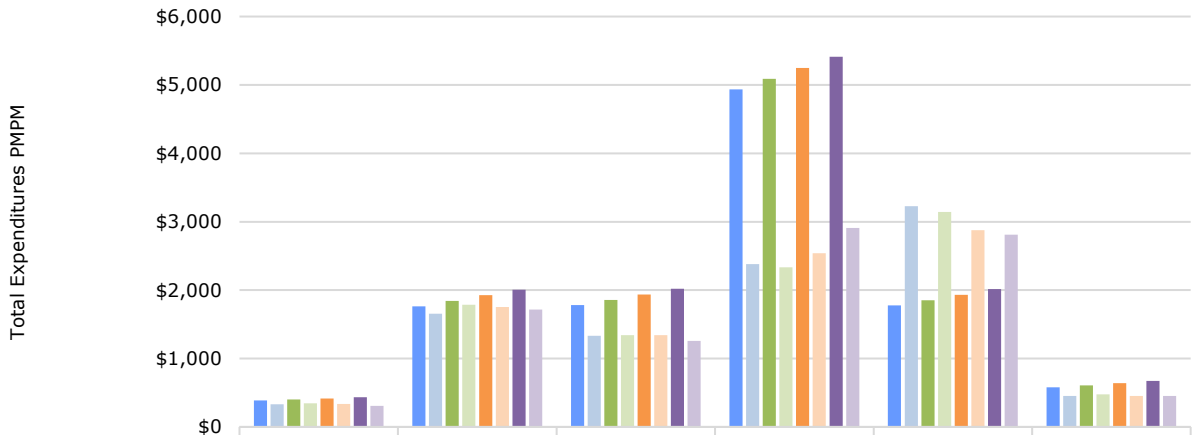
In addition, the PMPM costs for all MEGs experienced decreases in the range of 0.2% to 7.2% from DY3 to DY4, apart from the NF LOC group. The PMPM reduction is particularly noteworthy for the NF LOC Dual population which is a particularly difficult population to manage and tends to have relatively higher costs per member. This group only saw a decrease of 2.3% from DY3 to DY4, but saw a significant decrease of 13.0% from $3,226.87 in DY1 to $2,808.73 in DY4.

The aggregate program PMPM decreased 3.8% from DY3 to DY4 and decreased 4.0% from DY1 to DY4. 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.

Exhibit 66.a – DY1 to DY4 PMPM Expenditures by MEG[101]

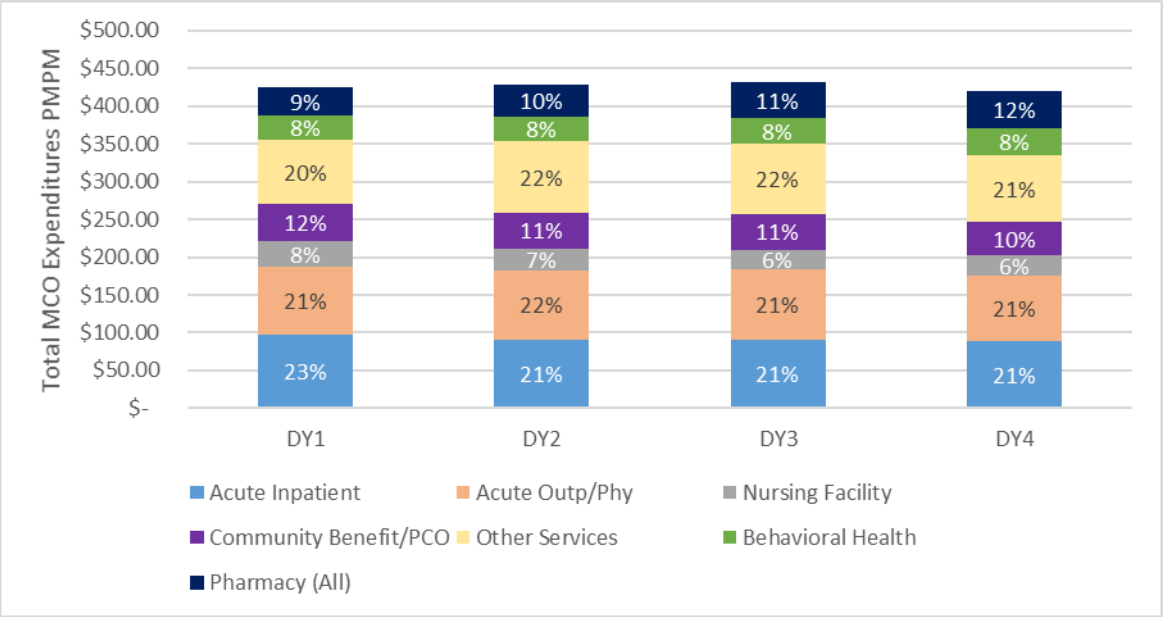


	TANF	SSI - Medicaid only	SSI - Dual	NF LOC	NF LOC Dual	Expansion Adults
DY1 STC	$385.80	$1,763.90	$1,780.77	$4,936.92	$1,776.90	$577.87
DY1 Centennial Care	$329.58	$1,656.04	$1,333.13	$2,380.17	$3,226.87	$454.01
DY2 STC	$400.77	$1,842.83	$1,857.34	$5,090.46	$1,853.31	$607.34
DY2 Centennial Care	$344.63	$1,784.27	$1,342.48	$2,331.82	$3,143.68	$477.22
DY3 STC	$416.32	$1,925.21	$1,937.21	$5,248.77	$1,933.00	$638.31
DY3 Centennial Care	$334.16	$1,752.70	$1,340.20	$2,541.14	$2,874.50	$452.75
DY4 STC	$432.47	$2,008.00	$2,020.51	$5,412.01	$2,016.12	$670.87
DY4 Centennial Care	$310.09	$1,715.13	$1,258.70	$2,908.55	$2,808.73	$452.02

[101] Source: Budget Neutrality tables, sourced from New Mexico Budget Neutrality Monitoring Spreadsheet, Attachment A, Quarter End December 2017.

The Evaluation also examined data summarized by the State's actuary which shows the distribution of PMPM program expenditures by service category for DY1 through DY4. As Exhibit 66.b illustrates, and consistent with measure 65 above, the distribution of PMPM expenditure has been relatively stable throughout DY1 to DY4. Notable trends from DY1 to DY4 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.

Exhibit 66.b – DY1 to DY4 PMPM Expenditure Distribution by Service Category[102]



[102] Source: Data summarized by the State's actuary based on financial statements submitted by MCOs. MCO expenditures are not the same as Centennial Care total program expenditures (which include program administrative expenses and other allowable expenses), though cost distribution across categories of service would generally align.

Measure 67 – Costs per user of services.

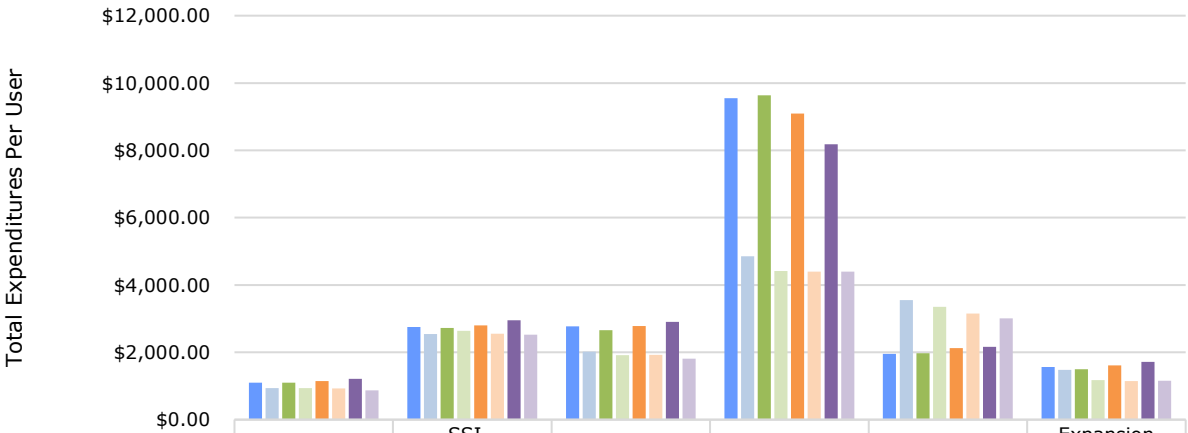
Exhibit 67 presents the calculated costs per user by MEG for DY1 through DY4 compared to the baseline costs. In the exhibit, "DYX STC" is the cost-per-user caps by MEG. As the exhibit illustrates, and consistent with measure 65, the costs for all MEGs remained below the MEG cost-per-user cap throughout DY1 to DY4 apart from NF LOC Dual MEG.

Consistent with results from the PMPM costs measure, the Per User Per Month (PUPM) costs for all MEGs experienced decreases from DY3 to DY4, apart from Group VIII (Medicaid-expansion eligible adults), which saw only a slight increase of 1.4%. These decreases in costs, which ranged from 0.1% to 6.1%, 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[103]



	TANF	SSI - Medicaid only	SSI - Dual	NF LOC	NF LOC Dual	Expansion Adults
DY1 STC	$1,100.51	$2,749.59	$2,769.23	$9,549.72	$1,958.76	$1,563.11
DY1 Centennial Care	$939.42	$2,540.92	$2,017.46	$4,848.78	$3,555.20	$1,474.95
DY2 STC	$1,095.17	$2,727.90	$2,653.87	$9,631.04	$1,973.33	$1,498.12
DY2 Centennial Care	$941.76	$2,641.21	$1,918.22	$4,411.74	$3,347.26	$1,177.14
DY3 STC	$1,150.37	$2,801.47	$2,780.84	$9,088.74	$2,121.33	$1,610.10
DY3 Centennial Care	$923.34	$2,550.44	$1,923.84	$4,400.22	$3,154.55	$1,142.04
DY4 STC	$1,208.64	$2,951.57	$2,901.88	$8,183.22	$2,160.49	$1,717.92
DY4 Centennial Care	$866.61	$2,521.08	$1,807.76	$4,397.87	$3,009.85	$1,157.51

[103] Source: Budget Neutrality tables, sourced from New Mexico Budget Neutrality Monitoring Spreadsheet, Attachment A, Quarter End December 2017; Cost Per User of Service MMIS reports.
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.

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 through DY4.

For inpatient PH services for specialty hospitals, the average length of stay increased from DY3 to DY4 despite the trend of decreasing average length of stay throughout the baseline to DY3. Days per 1,000 were relatively consistent from DY3 to DY4, but admits per 1,000 experienced a decrease from DY3 to DY4, resulting in the increase in the average length of stay. For baseline to DY4, the days per 1,000 and admits per 1,000 are staying substantially above the baseline, while the average length of stay is staying substantially below the baseline, which is consistent with DY3. For acute hospitals, there were notable decreased in each subcomponent (days per 1,000, admits per 1,000, average length of stay) both from DY3 to DY4 and from the baseline to DY4.

For other PH services, there was a minor increase in visits per 1,000 for outpatient surgeries (1.3%) and a major increase (22.1%) for outpatient hospital visits to urgent care from DY3 to DY4. There was also a notable increase (28.5%) in non-emergent transportation trips from DY3 to DY4, but this is generally a smaller year-over-year increase that what has been seen in prior years.

Inpatient LTSS services (including acute hospitals, specialty hospitals, and hospital swing bed) showed mixed performance results across reporting periods. From DY3 to DY4, utilization of both acute and specialty hospital services generally experienced decreases in days per 1,000, admits per 1,000, and average length of stay which is consistent with results from the baseline to DY4; only average length of stay in specialty hospitals experienced a significant increase from the baseline to DY4.

NF care for high levels of care experienced decreases in utilization, while low levels of care experienced increases in utilization from the baseline to DY4. 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 DY4 include the use of personal care services (100.7% for T1019, 244.6% for 99509), outpatient urgent care (151.4%), and non-emergent transportation (15,513.9%). Outpatient surgery visits experienced a slight decrease (-15.9%) from the baseline to DY4.

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[104]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	Diff. from Baseline	DY3	Diff. from DY2	Diff. from Baseline	DY4	Diff. from DY3	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%	398.0	-71.4%	-81.5%
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%	82.3	-62.7%	-70.7%
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%	4.8	-23.4%	-36.9%
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%	26.1	2.2%	37.2%
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%	1.9	-12.9%	74.0%
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%	14.0	17.3%	-21.2%
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%	17.1	1.3%	19.1%
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%	61.0	22.1%	94.9%
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	361.1	28.5%	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%	99.4	-37.8%	-69.7%
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%	1,792.9	-12.7%	-3.1%
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%	2,024.7	-15.9%	-68.5%
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%	22,101.6	4.8%	12.1%
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%	0.0	-100.0%	-100.0%
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%	0.0	N/A	-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%	898,486.1	15.6%	100.7%
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%	136,167.4	12.0%	244.6%
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%	1,084.9	-30.1%	-55.3%
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%	181.7	-14.2%	-37.9%
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%	6.0	-18.5%	-28.1%
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%	98.4	-25.6%	-73.9%
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%	4.3	-40.8%	-92.0%
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%	22.8	25.8%	227.5%
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%	55.1	-7.0%	-15.9%
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%	26.0	10.2%	151.4%
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%	4,947.0	-0.3%	15,513.9%

[104] Source: Utilization reports (Report 3) contained within the 2014 – 2017 annual supplemental FIN reports.
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.

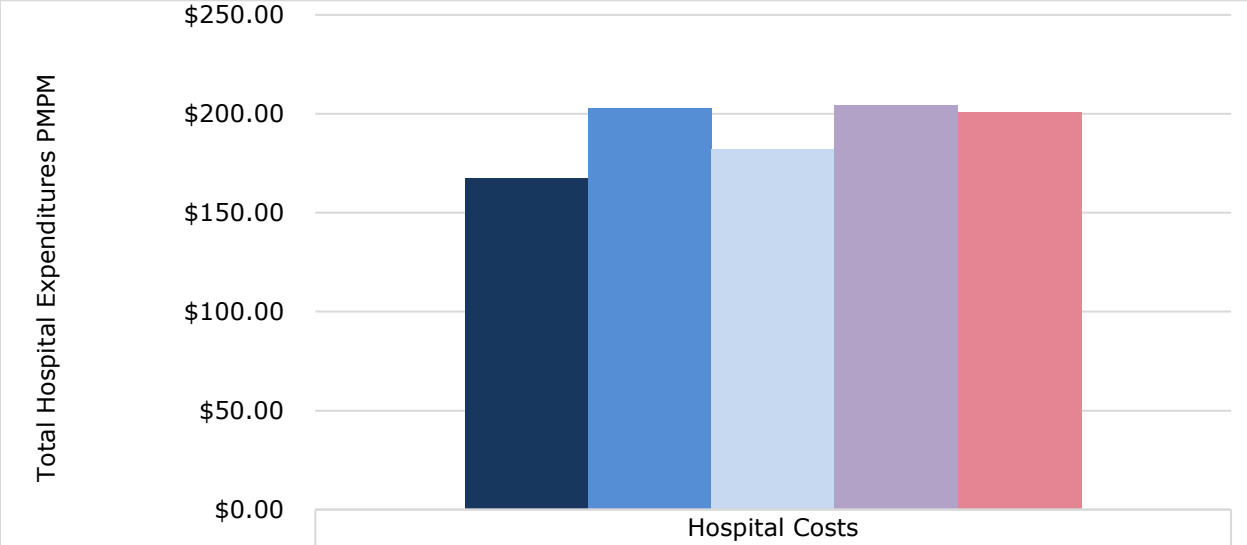
Measure 69 – Hospital costs.

Exhibit 69 presents the PMPM cost for services that are associated with hospital, clinic, and facility visits for DY1 through DY4 compared to the baseline PMPM[105]. As illustrated, the average PMPM across all hospital services experienced a 12.4% year-over-year increase in DY3 followed by a 1.9% year-over year decrease in DY4, 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[106]



	Hospital Costs
Q1 2014 Baseline	$167.53
DY1 Centennial Care	$202.74
DY2 Centennial Care	$182.03
DY3 Centennial Care	$204.53
DY4 Centennial Care	$200.64

[105] Refer to Appendix A for a complete listing of all services included in this measure

[106] Source: Revenue and expense reports (Report 1) contained within the 2014 – 2017 annual supplemental FIN reports. 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.

Measure 70 – Use of HCBS.

Centennial Care provides members meeting a NF LOC access to LTSS through Community Benefit (CB) services (i.e., HCBS) without a waiver 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).

In DY1 a total of 24,022 individuals accessed the community benefit (ABCB and SDCB combined) for both LTSS and Expansion Adults. The number of individuals accessing the community benefit increased by 3,856 in DY2 and 1,976 in DY3. In DY4 the unique number of individuals decreased by 114 to 29,740. For the period between DY1 and DY4 the number of individuals accessing community benefit services increased by 7.4% annualized.

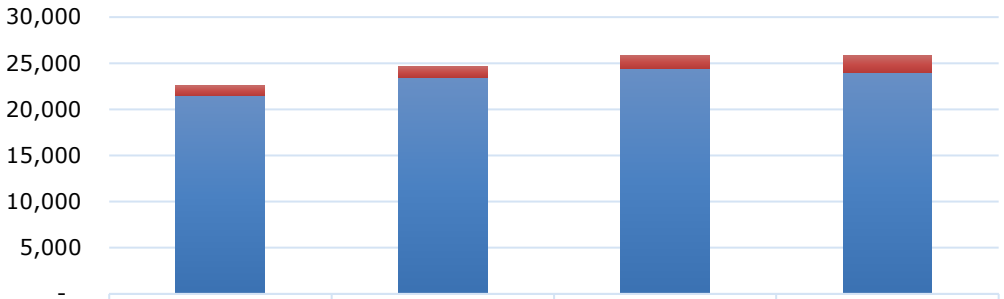
As newer members accessed the community benefit the average cost for community benefit services decreased. This decrease was likely due to the ramp-up period and that newer individuals required less services than the population using the community benefit prior to DY1.

Exhibits 70.a, 70.b, and 70.c illustrate the growth of individuals accessing the community benefit by population and community benefit model (ABCB vs SDCB). In addition, Exhibits 70.d, 70.e, and 70.f illustrate the average cost of community benefit services by demonstration year. Finally, Exhibits 70.g and 70.h provide the top 10 services by total expenditures for ACBS and SDCB community benefit for the reporting period between DY1 and DY4.

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

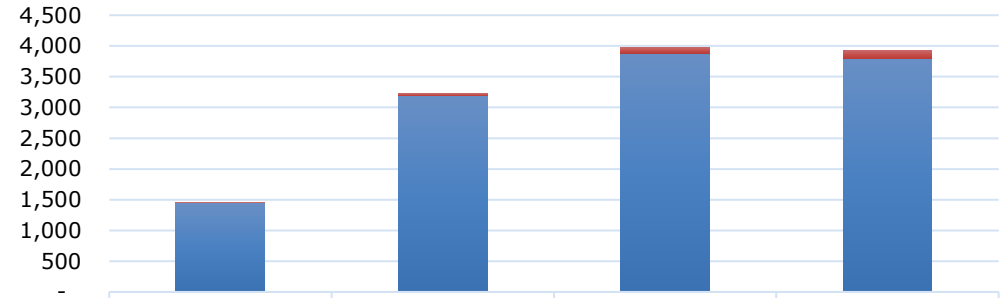
Statistical significance was not calculated for this measure based on the timing of available data.

Exhibit 70.a – Number of LTSS Members Using Community Benefit by Benefit Model[107]



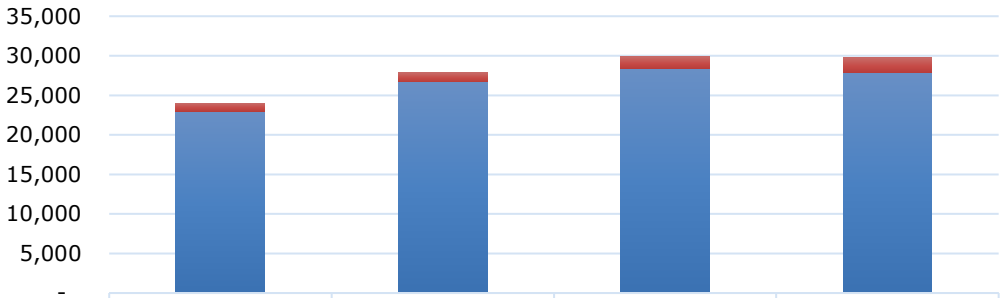
	DY1	DY2	DY3	DY4
SDCB	1,019	1,137	1,402	1,758
ABCB	21,543	23,510	24,479	24,052

Exhibit 70.b – Number of Expansion Members Using Community Benefit by Benefit Model



	DY1	DY2	DY3	DY4
SDCB	4	38	89	141
ABCB	1,456	3,193	3,884	3,789

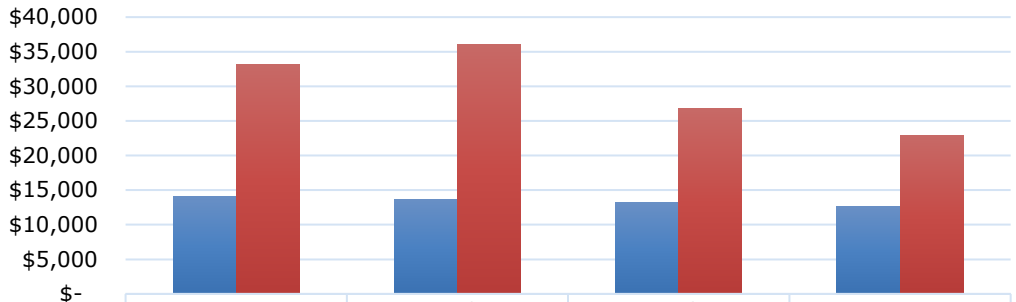
Exhibit 70.c – Total LTSS and Expansion Members Using Community Benefit by Benefit Model



	DY1	DY2	DY3	DY4
SDCB	1,023	1,175	1,491	1,899
ABCB	22,999	26,703	28,363	27,841

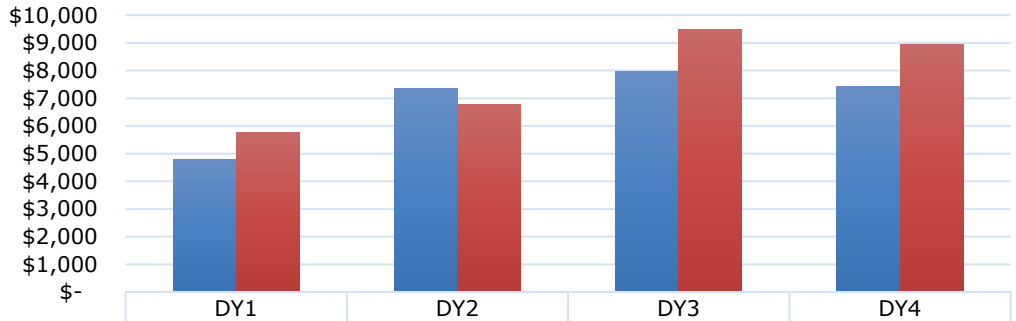
[107] Source: Use of HCBS cost and utilization MMIS report. Note the data source was revised to allow greater reporting of detailed categories of service and population cohorts.

Exhibit 70.d – Average Cost Per LTSS User of Community Benefit by Benefit Model[108]



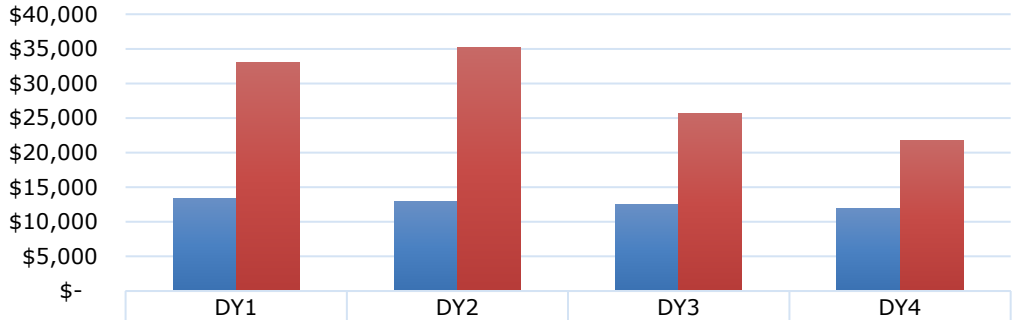
	DY1	DY2	DY3	DY4
ABCB	$14,023	$13,673	$13,161	$12,563
SDCB	$33,167	$36,080	$26,745	$22,831

Exhibit 70.e – Average Cost Per Expansion User of Community Benefit by Benefit Model



	DY1	DY2	DY3	DY4
ABCB	$4,772	$7,356	$7,968	$7,441
SDCB	$5,773	$6,767	$9,472	$8,939

Exhibit 70.f – Average Cost for Expansion and LTSS Users of Community Benefit by Benefit Model



	DY1	DY2	DY3	DY4
ABCB	$13,438	$12,918	$12,450	$11,866
SDCB	$33,060	$35,132	$25,714	$21,799

[108] Source: Use of HCBS cost and utilization MMIS report. Note the data source was revised to allow greater reporting of detailed categories of service and population cohorts.

Exhibit 70.g – Top 10 Agency-Based Community Benefit Services by Expenditures (DY1 – DY4)[109]

Rank	Procedure Code		DY1-DY4 Units	DY1 - DY4 Expenditures	Average Unit Cost
1	99509 & T1019	Personal Care (hr)	84,528,947	$ 1,194,009,777	$ 14.13
2	G9006	Personal Care Directed-Admin Fee (per service)	409,223	$ 79,141,349	$ 193.39
3	S5165	Environmental Modification (project)	6,986	$ 28,147,807	$ 4,029.17
4	T2031	Assisted Living Waiver (per diem)	384,032	$ 20,548,206	$ 53.51
5	99509U1	Respite (hr)	493,389	$ 6,370,609	$ 12.91
6	S5110	Personal Care-Directed Training	320,075	$ 3,319,636	$ 10.37
7	S5161	Emergency Response (month)	89,608	$ 3,160,623	$ 35.27
8	S5100	Adult Day Health (15 min)	524,338	$ 1,086,349	$ 2.07
9	T1002	PDN for Adults - RN (15 min)	73,584	$ 842,243	$ 11.45
10	T2038	Community Transition Services (service)	289	$ 545,588	$ 1,887.85
All Other			15,792	$ 301,101	$ 19.07

Exhibit 70.g – Top 10 Self-Directed Community Benefit Services by Expenditures (DY1 – DY4)

Rank	Procedure Code		DY1-DY4 Units	DY1 - DY4 Expenditures	Average Unit Cost
1	99509	Homemaker (hr)	10,350,511	$ 136,363,887	$ 13.17
2	T1999	Related goods	41,444	$ 4,208,883	$ 101.56
3	99509U1	Respite (hr)	218,436	$ 3,202,058	$ 14.66
4	T1005	Respite (15 min)	550,528	$ 1,855,320	$ 3.37
5	97124	Massage Therapy (15 min)	64,898	$ 1,529,219	$ 23.56
6	S5165	Environmental Modification (project)	614	$ 1,489,513	$ 2,425.92
7	T2049	Non-Medical Transportation (mile)	2,558,546	$ 1,343,550	$ 0.53
8	S5100	Adult Day Health (15 min)	221,831	$ 1,210,642	$ 5.46
9	H2021	Community Service Wrap Around (15 min)	182,771	$ 739,454	$ 4.05
10	T2033	Residential Care NOS (per diem)	3,301	$ 729,397	$ 220.96
All Other			124,227	$ 2,164,369	$ 17.42

[109] Source: Use of HCBS cost and utilization MMIS report. Note the data source was revised to allow greater reporting of detailed categories of service and population cohorts.

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 through DY4. The days per 1,000 subcomponent decreased 40.2% and the admits per 1,000 subcomponent decreased 28.6%, resulting in a 16.3% decrease in the average length of stay from DY3 to DY4.

Despite this decrease in the most recent year, the days per 1,000 subcomponent increased 22.8% while the admits per 1,000 subcomponent decreased 78.4%, resulting in a 467.6% increase in the average length of stay from the baseline to DY4.

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)[110]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	Diff. from Baseline	DY3	Diff. from DY2	Diff. from Baseline	DY4	Diff. from DY3	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%	93.4	-40.2%	22.8%
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%	4.5	-28.6%	-78.4%
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%	20.8	-16.3%	467.6%

[110] Source: Utilization reports (Report 3) contained within the 2014 – 2017 annual supplemental FIN reports.
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.

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 and DY1 through DY4. From DY3 to DY4, the utilization of RTCs (-8.8%) and average length of stay for psychiatric hospitalization service (-1.8%) decreased while utilization for foster care therapeutic (7.5%) and Federally Qualified Health Centers (FQHCs) (9.9%) increased. Similar to DY3 to DY4 trends in performance change, the utilization of RTCs (-17.2%) and average length of stay for psychiatric hospitalization service (-13.8%) decreased while utilization for foster care therapeutic (33.8%) and FQHCs (82.2%) increased from the baseline to DY4.

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[111]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	Diff. from Baseline	DY3	Diff. from DY2	Diff. from Baseline	DY4	Diff. from DY3	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%	179.6	-8.8%	-17.2%
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%	171.1	7.5%	33.8%
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%	83.4	-19.1%	47.3%
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%	11.5	-17.6%	70.9%
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%	7.2	-1.8%	-13.8%
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%	269.4	9.9%	82.2%

[111] Source: Utilization reports (Report 3) contained within the 2014 – 2017 annual supplemental FIN reports.
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.

Measure 73 – Use of substance abuse services.

Exhibit 73 presents the annualized utilization for services related to substance abuse from Q1 2014 baseline through DY4. In the MCO financial reports, methadone treatment was the only category of service determined to be specifically characterized as a substance abuse service, which experienced an increase in visits per 1,000 of 100.6% from DY3 to DY4, and a total increase from the baseline to DY4 of 736.0%.

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[112]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	Diff. from Baseline	DY3	Diff. from DY2	Diff. from Baseline	DY4	Diff. from DY3	Diff. from Baseline
USE OF SUBSTANCE ABUSE SERVICES													
Methadone Treatment	Vists per 1,000	44.9	65.9	46.8%	137.7	108.9%	206.7%	187.1	35.9%	316.8%	375.3	100.6%	736.0%

[112] Source: Utilization reports (Report 3) contained within the 2014 – 2017 annual supplemental FIN reports.
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.

Measure 74 – Use of pharmacy services.

Exhibit 74 presents the annualized utilization for services related to pharmacy in the Q1 2014 baseline through DY4. Generally, there were decreases in the number of scripts per 1,000 for brand and generic drugs in the PH, BH, and LTSS care settings from DY3 to DY4, with decreases in the range of 5.0% to 6.8%. However, there were increases in drug utilization in BH brand drugs (6.0%) and significant increases in other drugs for the PH setting (26.6%) and LTSS setting (69.3%), but a decrease (-31.2%) in the BH setting.

Similar to the DY3 to DY4 period, most drug utilization decreased across BH and LTSS care settings from the baseline to DY4, with decreases in the range of 3.0% to 98.8%. The only increases in scripts per 1,000 were for brand (2.8%) and generic drugs (10.3%) in the PH setting and an increase in other drugs in the LTSS setting (104.5%).

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.

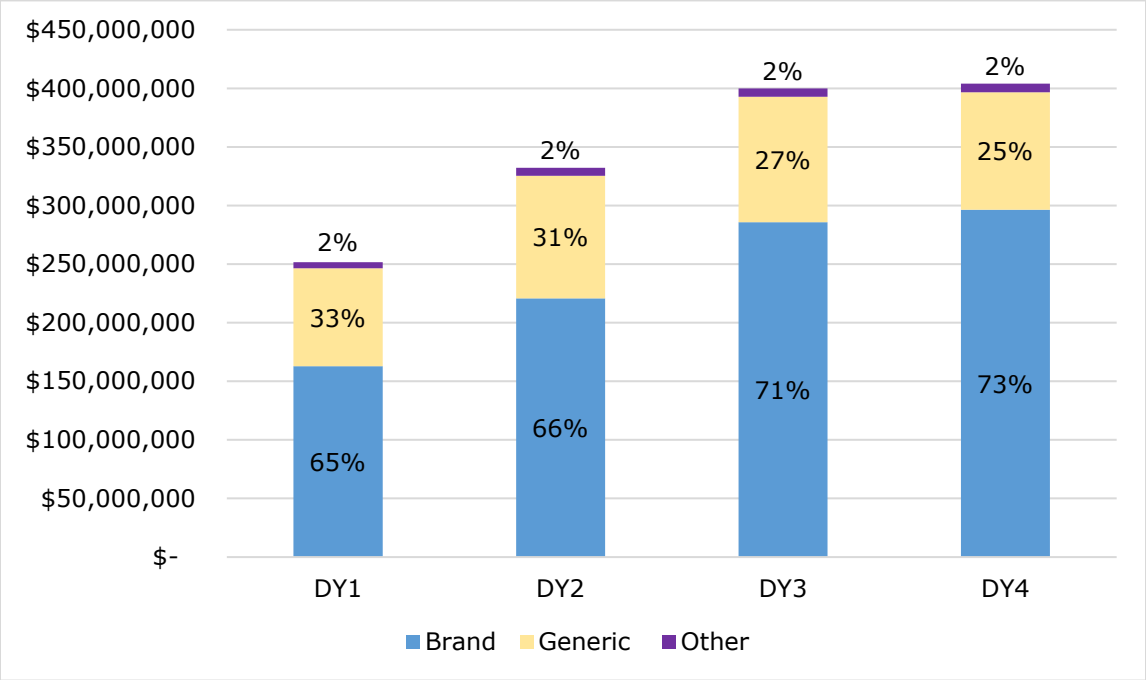
Exhibit 74 – Use of Pharmacy Services[113]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	Diff. from Baseline	DY3	Diff. from DY2	Diff. from Baseline	DY4	Diff. from DY3	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%	865.3	-5.3%	2.8%
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%	6,052.6	-5.7%	10.3%
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%	30.8	26.6%	-82.9%
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%	150.1	6.0%	-18.1%
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%	1,661.9	-5.0%	-3.0%
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%	0.8	-31.2%	-98.8%
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%	1,303.5	-6.8%	-22.3%
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%	8,103.6	-6.5%	-15.7%
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%	732.9	69.3%	104.5%

[113] Source: Utilization reports (Report 3) contained within the 2014 – 2017 annual supplemental FIN reports.
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.

The Evaluation also examined data summarized by the State's actuary which shows the distribution of pharmacy expenditures for DY1 through DY4. As illustrated in Exhibit 74, total drug expenditures have been increasing throughout DY1 to DY4, with a 1.0% increase from DY3 to DY4. In addition, pharmacy expenditure has been shifting from generic drugs to brand name drugs from DY1 to DY4. 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, a swifter Food and Drug Administration approval process for new drugs in recent years, etc. In DY4, brand name drug expenditure made up 73% of total drug cost, while generic drugs accounted for 25%.

Exhibit 74 – Distribution of Pharmacy Expenditures by Brand, Generic, and Other Drugs[114]



[114] Source: Data summarized by the State's actuary 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 through DY4. While the percentage of high cost inpatient service expenditure dropped each year from DY1 to DY3, this percentage increased slightly in DY4 with high cost inpatient claims representing 1.7% of total healthcare related expenditures in DY4.

Overall the percentage of inpatient services exceeding $50,000 represented a small proportion of total healthcare related expenditures and the proportion of DY4 expenditures was 2.5% lower than the proportion of DY1 expenditures.

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 a Percentage of Total Healthcare Expenditures[115]

	DY1	DY2	DY3	DY4
Baseline	4.1%	4.1%	4.1%	4.1%
Measured Total	4.1%	2.5%	1.3%	1.7%
Difference Measured Over/(Under) Baseline	0.0%	-1.7%	-2.8%	-2.5%

[115] Source: Revenue and expense reports and high cost claims reports (Report 1 and Report 7) contained within the 2014 – 2017 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 through DY4. While the PMPM cost of diagnostic imaging service increased substantially in DY3 and exceeded the baseline by 22.4%, it decreased slightly to fall closer in line with baseline and DY1 costs, exceeding the baseline by just 6.0%.

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[116]

	Q1 2014	DY1	DY2	DY3	DY4
Baseline	$0.67	$0.67	$0.67	$0.67	$0.67
Measured Total	$0.67	$0.71	$0.49	$0.82	$0.71
Measured Over/(Under) Baseline	$0.00	$0.04	-$0.18	$0.15	$0.04
% Measured Over/(Under) Baseline	0.0%	6.0%	-26.9%	22.4%	6.0%

[116] Source: Expense reports (Report 2) contained within the 2014 – 2017 annual supplemental FIN reports.
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.

Measure 77 – Emergency department use.

Exhibit 77 presents ER utilization for the Q1 2014 baseline through DY4. As the exhibit illustrates, utilization for ER services increased in both PH and LTSS care settings from the baseline to DY4, which is an undesirable trend given that ER services are high cost in nature. Further, ER utilization experienced its first annual increase from DY3 to DY4 after 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.

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[117]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	Diff. from Baseline	DY3	Diff. from DY2	Diff. from Baseline	DY4	Diff. from DY3	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%	569.6	2.4%	3.1%
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%	858.0	16.7%	55.3%

[117] Source: Utilization reports (Report 3) contained within the 2014 – 2017 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.
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.

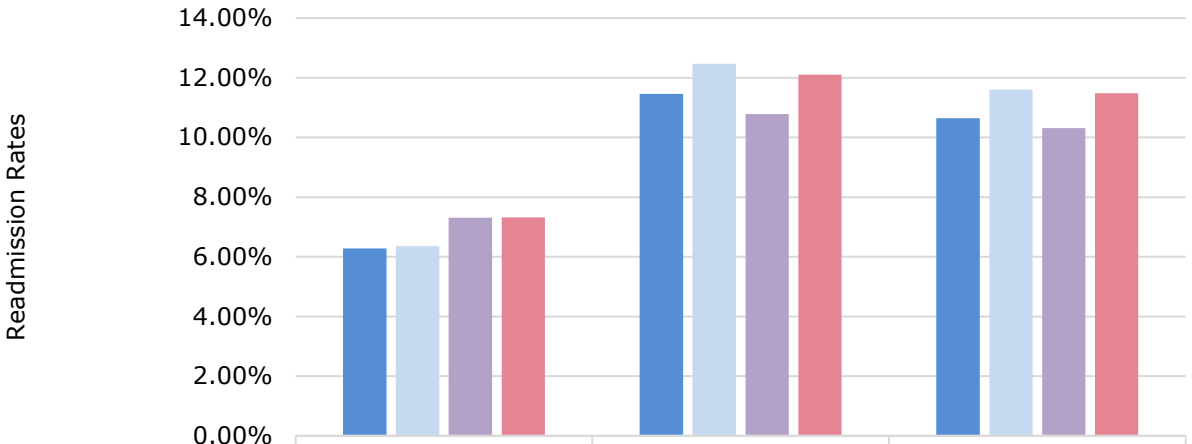
Measure 78 – All cause readmissions.

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 through DY4. As illustrated, all cause readmission rates increased for both the 2-17 years of age cohort (0.1%) and the 18+ years of age cohort (12.3%), which resulted in an 11.2% increase in the weighted average readmission rate from DY3 to DY4. 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[118]



	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	6.35%	12.47%	11.60%
DY3 Centennial Care	7.31%	10.78%	10.32%
DY4 Centennial Care	7.32%	12.11%	11.48%

[118] Source: NM HEDIS rates calculated by the State's actuary for 2014 – 2017. HSD/MAD indicated a data source change for this measure starting in DY2 to replace MMIS data with summary data produced by the State's actuary. 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. 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.

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 through DY4. The utilization of psychiatric hospitals stayed relatively consistent throughout the baseline to DY4, at around 1.3 encounters per client.

There was a slight decrease (-26.7%) in utilization of RTCs from DY3 to DY4, but overall the utilization increased from 1.04 encounters per client to 4.39 encounters per client (a 321.5% percentage increase) from the baseline to DY4. This increase from the baseline to DY4 was driven by a significant increase in utilization from the baseline to DY1 (1.04 encounters per client to 11.33 encounters per client), and utilization has been decreasing annually from DY1 to DY4.

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[119]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	Diff. from Baseline	DY3	Diff. from DY2	Diff. from Baseline	DY4	Diff. from DY3	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%	1.26	-3.1%	-2.0%	1.30	3.0%	0.9%
Residential Treatment Center	Encounters per Client	1.04	11.33	987.9%	8.16	-28.0%	683.6%	5.99	-26.6%	475.1%	4.39	-26.7%	321.5%

[119] Source: Inpatient mental health and substance use MMIS reports. Note that claims analysis criteria was revised between DY2 and DY3 to account for the ICD-9 changeover to ICD-10. These services are provided to the children population only.
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.

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 regimens 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 reviewed 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 for the population as a whole.

Overall through DY4 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.

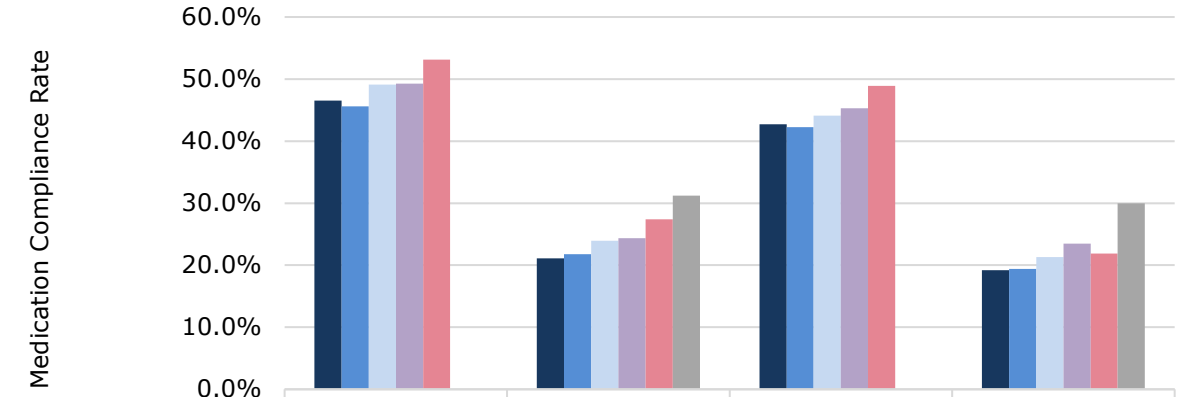
Measure 80 – Asthma controller medication compliance (children).

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 through DY4 and the 2017 HEDIS Medicaid national average for the 75% compliance threshold.

Aggregate compliance rates increased from DY3 to DY4 for all compliance thresholds and age cohorts except the 75% compliance rate for the 12-18 age cohort which experienced a 6.6% decrease that was not statistically significant at the 95% confidence level. The increases for the 50% compliance rate for both age cohorts and the 75% compliance rate for the 5-11 age cohort were all statistically significant at the 95% confidence level.

Aggregate compliance rates increased from the baseline to DY4 for all thresholds and age cohorts, with the change in 50% compliance rate for both age cohorts and the 75% compliance rate for the 5-11 age cohort each experiencing increases that were statistically significant at the 95% confidence level.

Exhibit 80.a – Asthma Medication Compliance for Children[120]



	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%
DY3 Centennial Care	49.3%	24.4%	45.3%	23.5%
DY4 Centennial Care	53.2%	27.4%	48.9%	21.9%
2017 National Avg	N/A	31.2%	N/A	30.0%

[120] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measure "mma").
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.

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 from DY3 to DY4. 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.

It is also important to note the experience related to reward redemption rates from DY1 to DY4. Asthma rewards experienced large increases in the redemption rates from DY1 to DY2, from 218% for the first asthma refill up to 516% for the twelfth asthma refill. These types of increases might be expected early on for a rewards program as members learn how the program works. What is often challenging for any disease management/intervention program is sustained engagement, and the continued year-over-year increases from DY2 to DY3 and again from DY3 to DY4 demonstrate a continually increased engagement of members with asthma.

Exhibit 80.b Centennial Rewards for Activities Related to Asthma in Children, DY1 – DY4[121]

		Cumulative DY1		Cumulative DY1-DY2		Cumulative DY1-DY3		Cumulative DY1-DY4	
Activity Group	Activity	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards
Asthma	1st Asthma	6,274	9.1%	11,152	29.1%	15,653	33.8%	18,499	35.5%
Asthma	3rd Asthma	4,771	8.6%	8,198	30.4%	11,258	34.4%	12,864	36.9%
Asthma	6th Asthma	2,510	7.5%	4,139	33.1%	6,108	34.7%	6,896	38.8%
Asthma	9th Asthma	1,246	5.9%	2,260	33.8%	3,669	34.6%	4,133	39.9%
Asthma	12th Asthma	663	5.7%	1,252	35.3%	2,426	32.4%	2,764	40.6%

		% DY1-DY2 Change		% DY2-DY3 Change		% DY3-DY4 Change	
Activity Group	Activity	% Change in Members Earning Rewards	% Change in Redemption Rates	% Change in Members Earning Rewards	% Change in Redemption Rates	% Change in Members Earning Rewards	% Change in Redemption Rates
Asthma	1st Asthma	77.7%	218.9%	40.4%	16.2%	18.2%	4.9%
Asthma	3rd Asthma	71.8%	252.6%	37.3%	13.2%	14.3%	7.4%
Asthma	6th Asthma	64.9%	340.2%	47.6%	4.8%	12.9%	11.7%
Asthma	9th Asthma	81.4%	476.3%	62.3%	2.6%	12.6%	15.2%
Asthma	12th Asthma	88.8%	516.0%	93.8%	-8.2%	13.9%	25.4%

[121] Source: Finity 2014-2017 member rewards data.

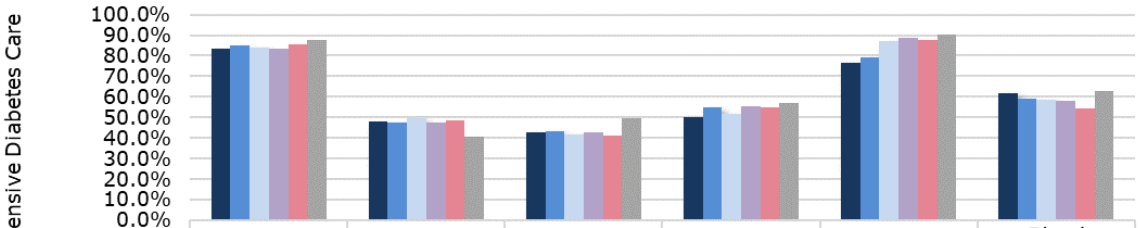
Measure 81 – Diabetes - annual recommended tests (A1C, LDL, eye exam, nephropathy exam).

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 through DY4 and the 2017 HEDIS Medicaid national average.

The only subcomponent that experienced an increase from DY3 to DY4 was HbA1c testing, which increased 2.6%. HbA1c control (<8.0%) decreased 3.5% and HbA1c poor control (>9.0%) experienced a negative increase of 1.6%. Eye Exam and Medical Attention for Nephropathy both decreased 1.3%. The largest decrease experienced was in the blood pressure controlled subcomponent at 6.3%, which was statistically significant at a 95% confidence level.

Three subcomponents experienced increases from baseline to DY4. Medical attention for nephropathy was the largest increase at 14.4% which was statistically significant at the 95% confidence level. The other two components that experienced increases were eye exams at 8.6% and HbA1c testing 2.7%. Blood pressure controlled experienced the largest decrease at 12.0%.

Exhibit 81.a – Comprehensive Diabetes Care[122]



	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%
DY3 Centennial Care	83.5%	47.6%	42.5%	55.4%	88.7%	58.2%
DY4 Centennial Care	85.7%	48.4%	41.0%	54.7%	87.6%	54.5%
2017 National Avg	87.6%	40.5%	49.4%	57.2%	90.1%	62.7%

[122] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measure "cdc").
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.

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 has increased in all categories from DY3 to DY4. The percentage of members redeeming rewards also increased across all categories from DY3 to DY4. Thus engagement in the program for members with diabetes remains fairly strong as of DY4. 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 – DY4[123]

		Cumulative DY1		Cumulative DY1-DY2		Cumulative DY1-DY3		Cumulative DY1-DY4	
Activity Group	Activity	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards
Diabetes	Eye Exam	9,874	8.0%	21,951	24.1%	28,433	29.3%	34,054	30.3%
Diabetes	HbA1c Test	18,135	9.2%	28,723	25.9%	36,482	29.5%	43,393	30.1%
Diabetes	LDL Test	13,569	9.2%	23,617	26.7%	30,968	30.0%	32,743	33.3%
Diabetes	Nephropathy Exam	14,944	9.0%	28,072	24.2%	35,036	28.5%	40,276	29.4%

		% DY1-DY2 Change		% DY2-DY3 Change		% DY3-DY4 Change	
Activity Group	Activity	% Change in Members Earning Rewards	% Change in Redemption Rates	% Change in Members Earning Rewards	% Change in Redemption Rates	% Change in Members Earning Rewards	% Change in Redemption Rates
Diabetes	Eye Exam	122.3%	203.5%	29.5%	21.6%	19.8%	3.2%
Diabetes	HbA1c Test	58.4%	180.9%	27.0%	13.9%	18.9%	2.2%
Diabetes	LDL Test	74.1%	190.8%	31.1%	12.1%	5.7%	11.2%
Diabetes	Nephropathy Exam	87.8%	168.2%	24.8%	17.8%	15.0%	2.9%

[123] Source: Finity 2014-2017 member rewards data.

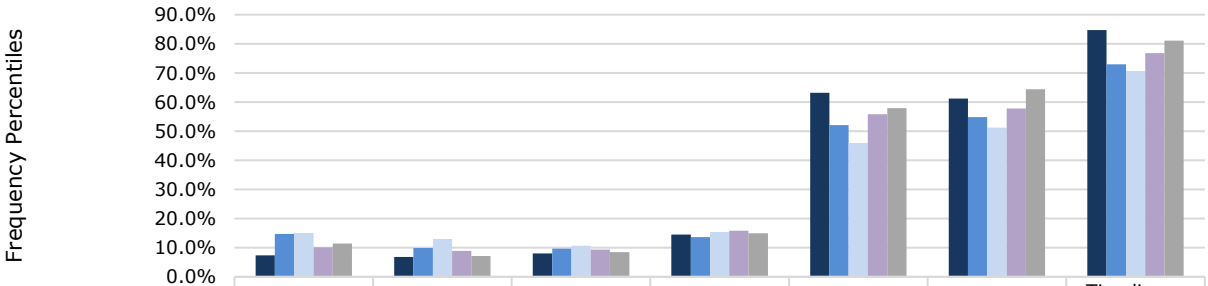
Measure 82 – Prenatal program.

Exhibit 82.a demonstrates compliance rates of frequency for ongoing prenatal care, postpartum care, and timeliness of prenatal care. The compliance rates for the frequency for ongoing prenatal care are shown for the 2013 baseline through DY4 (as available) and the HEDIS Medicaid national average for the applicable measurement year. The HEDIS measure for the frequency for ongoing prenatal care was removed for the 2017 measurement year, so there is no DY4 HEDIS data available.

For the frequency of ongoing prenatal care, three subcomponents had statistically significant rates of change from DY2 to DY3. The percentage of deliveries that received under 21% of expected visits decreased 33.3%, the percentage of deliveries that received 21-40% of expected visits decreased 31.2%, and the percentage of deliveries that received over 81% of expected prenatal visits increased 21.5%. Two subcomponents experienced rates of change that are not statistically significant: deliveries that received between 41-60% decreased 11.9% and between 61-80% expected visits increased 3.2%. This general shift in the distribution from lower expected visit percentiles to higher expected visit percentiles is a positive outcome for the most recent year of available data. However, from the baseline to DY3, lower frequencies of expected prenatal visits increased (deliveries receiving under 21% expected visits increased 36.6%, deliveries receiving 21-40% expected visits increased 30.4%, and deliveries receiving 41-60% expected visits increased 16.4%), while the percentage of deliveries that received 61-80% expected visits or over 81% of expected prenatal visits increased 9.0% and decreased 11.7%, respectively. The total expected visits in the two highest percentile subcomponents combined together were lower than the combined subcomponents for the 2016 national averages in DY3.

For postpartum care and timeliness of prenatal care, the percentage of deliveries that received postpartum care decreased 1.1%, although this decline was not statistically significant at the 95% confidence level. Timeliness of prenatal care rates experienced a statistically significant decrease from DY3 to DY4 of 4.8%. For the rates of change from the baseline to DY4, the percentage of deliveries that received postpartum care decreased 6.6%, and the timeliness of prenatal care decreased 13.8%. All changes from the baseline to DY4 were statistically significant at the 95% confidence level.

Exhibit 82.a – Prenatal Program[124]



	<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%
DY3 Centennial Care	10.1%	8.9%	9.4%	15.8%	55.8%	57.8%	76.8%
National Avg*	11.4%	7.1%	8.5%	14.9%	57.9%	64.4%	81.1%

*Note that the HEDIS Medicaid national averages are from measurement year 2016 for the Frequency of Ongoing Prenatal Care percentiles and from measurement year 2017 for both Postpartum Care and Timeliness of Prenatal Care.

[124] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measures "fpc" and "ppc").
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.

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 DY4. 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 – DY4[125]

		Cumulative DY1		Cumulative DY1-DY2		Cumulative DY1-DY3		Cumulative DY1-DY4	
Activity Group	Activity	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards
Pregnancy	Prenatal Enrollment	3,441	10.8%	7,386	24.0%	10,322	27.4%	14,085	26.8%

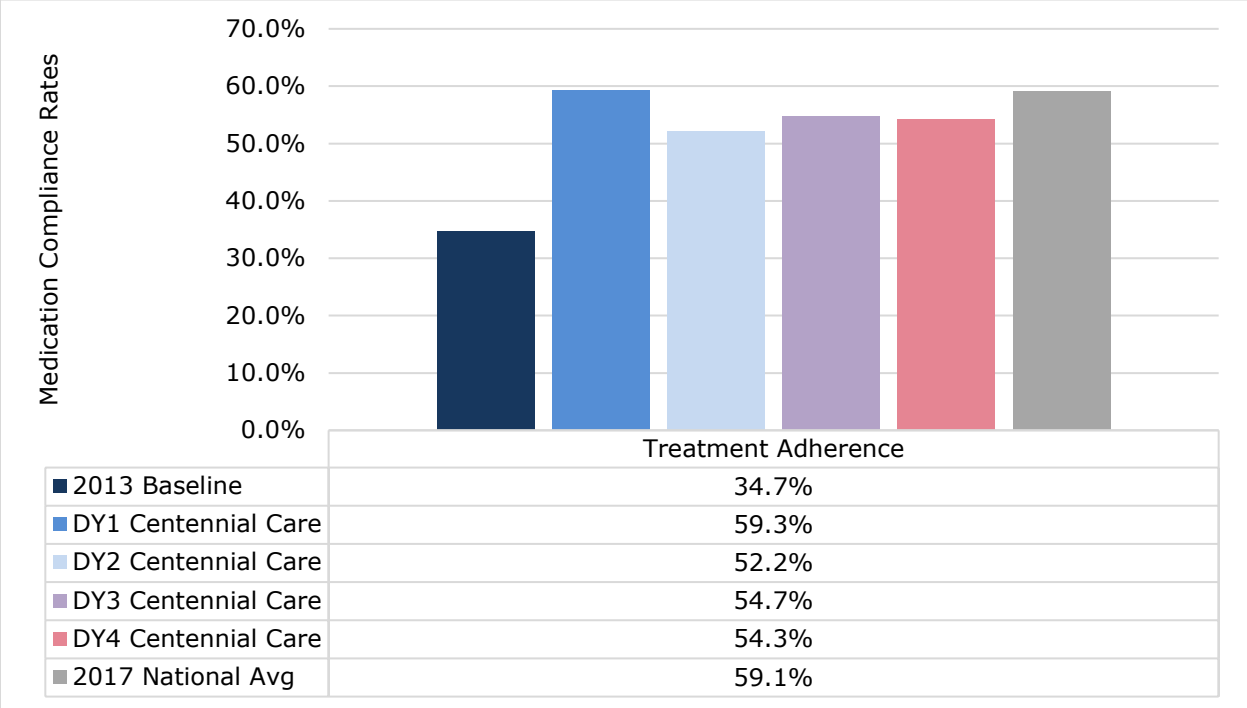
		% DY1-DY2 Change		% DY2-DY3 Change		% DY3-DY4 Change	
Activity Group	Activity	% Change in Members Earning Rewards	% Change in Redemption Rates	% Change in Members Earning Rewards	% Change in Redemption Rates	% Change in Members Earning Rewards	% Change in Redemption Rates
Pregnancy	Prenatal Enrollment	114.6%	122.4%	39.8%	14.5%	36.5%	-2.5%

[125] Source: Finity 2014-2017 member rewards data.

Measure 83 – Treatment adherence – schizophrenia.

Exhibit 83.a presents the schizophrenia treatment adherence rate for the 2013 baseline through DY4 and the 2017 HEDIS Medicaid national average. Although the treatment adherence rate declined 0.8% from DY3 to DY4, the aggregate change from the baseline to DY4 was a statistically significant increase of 56.4%. The DY4 performance was below the national average rate for 2017.

Exhibit 83.a – Treatment Adherence – Schizophrenia[126]



	Treatment Adherence
2013 Baseline	34.7%
DY1 Centennial Care	59.3%
DY2 Centennial Care	52.2%
DY3 Centennial Care	54.7%
DY4 Centennial Care	54.3%
2017 National Avg	59.1%

[126] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measure "saa").
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.

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 DY4. 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 – DY4[127]

		Cumulative DY1		Cumulative DY1-DY2		Cumulative DY1-DY3		Cumulative DY1-DY4	
Activity Group	Activity	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards
Schizophrenia	1st Schizophrenia	3,083	6.8%	4,718	19.9%	6,112	22.7%	7,612	23.1%
Schizophrenia	3rd Schizophrenia	2,515	6.7%	3,888	21.0%	5,065	23.2%	6,164	24.3%
Schizophrenia	6th Schizophrenia	1,944	6.0%	3,038	22.0%	4,148	23.0%	5,097	24.6%
Schizophrenia	9th Schizophrenia	1,570	5.2%	2,460	22.4%	3,545	22.7%	4,313	25.3%
Schizophrenia	12th Schizophrenia	1,100	5.2%	1,885	22.2%	3,029	21.4%	3,732	25.0%

		% DY1-DY2 Change		% DY2-DY3 Change		% DY3-DY4 Change	
Activity Group	Activity	% Change in Members Earning Rewards	% Change in Redemption Rates	% Change in Members Earning Rewards	% Change in Redemption Rates	% Change in Members Earning Rewards	% Change in Redemption Rates
Schizophrenia	1st Schizophrenia	53.0%	190.8%	29.5%	13.9%	24.5%	1.8%
Schizophrenia	3rd Schizophrenia	54.6%	213.8%	30.3%	10.7%	21.7%	4.8%
Schizophrenia	6th Schizophrenia	56.3%	268.5%	36.5%	4.4%	22.9%	7.1%
Schizophrenia	9th Schizophrenia	56.7%	328.8%	44.1%	1.1%	21.7%	11.7%
Schizophrenia	12th Schizophrenia	71.4%	327.9%	60.7%	-3.5%	23.2%	16.7%

[127] Source: Finity 2014-2017 member rewards data.

Measure 84 – Osteoporosis management in elderly women - females aged 65+ years.

Exhibit 84.a presents data on osteoporosis management in elderly women for the 2013 baseline through DY4. The number of unique clients and unique encounters both increased significantly from the baseline to DY4 (271.7% and 292.9% respectively). Furthermore, the more relevant subcomponent is the number of unique encounters per client, which increased by 5.7% from the baseline to DY4. Nearly all subcomponents have consistently seen year-over-year increases throughout Centennial Care, which is a positive outcome.

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 84.a – Osteoporosis Management in Elderly Women – Females Age 65+ Years[128]

Program Measure	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	DY3	Diff. from DY2	DY4	Diff. from DY3	Diff. from Baseline
Unique Count of Clients	106	159	50.0%	227	42.8%	253	11.5%	394	55.7%	271.7%
Unique Count of Encounter Claims	127	195	53.5%	271	39.0%	297	9.6%	499	68.0%	292.9%
Unique Count of Encounter per Client	1.20	1.23	2.4%	1.19	-2.7%	1.17	-1.7%	1.27	7.9%	5.7%

Exhibit 84.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 have increased substantially from DY3 to DY4, and the percentage of members redeeming rewards experienced slight increases. This may suggest the Centennial Rewards program incentivizes greater compliance and ownership for personal health for those registered and active in the program compared to the broader Centennial Care population.

Exhibit 84.b – Centennial Rewards for Bone Density Testing, DY1 – DY4[129]

		Cumulative DY1		Cumulative DY1-DY2		Cumulative DY1-DY3		Cumulative DY1-DY4	
Activity Group	Activity	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards
Bone Density	Bone Density Test	374	5.1%	749	20.3%	1,256	22.5%	1,899	23.1%

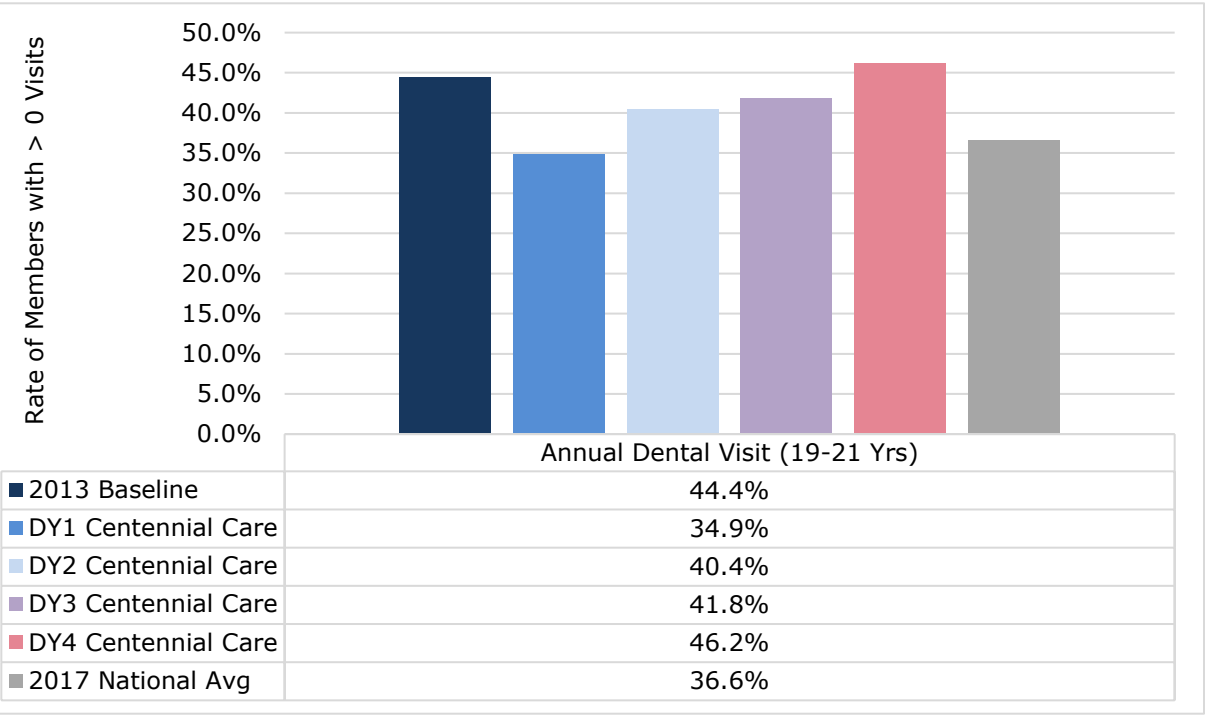
		% DY1-DY2 Change		% DY2-DY3 Change		% DY3-DY4 Change	
Activity Group	Activity	% Change in Members Earning Rewards	% Change in Redemption Rates	% Change in Members Earning Rewards	% Change in Redemption Rates	% Change in Members Earning Rewards	% Change in Redemption Rates
Bone Density	Bone Density Test	100.3%	299.5%	67.7%	11.0%	51.2%	2.4%

[128] Source: Osteoporosis MMIS Report. Note that claims analysis criteria was revised between DY2 and DY3 to account for the ICD-9 changeover to ICD-10.
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.
[129] Source: Finity 2014-2017 member rewards data.

Measure 85 – Annual dental visit – adult.

Exhibit 85.a illustrates frequency of dental visits among members 19-21 years of age for the 2013 baseline through DY4 and the 2017 HEDIS Medicaid national average. The percentage of young adults receiving at least one dental visit annually experienced an increase of 10.6% from DY3 to DY4, while the percentage experienced an increase of 4.0% from the baseline to DY4. Both increases are statistically significant at the 95% confidence level. Despite the decrease early in the Centennial Care program, continuous annual improvement characterized this important preventive care service. It is important to note that DY4 performance was above the 2017 HEDIS Medicaid national average.

Exhibit 85.a – Annual Dental Visit – Adult[130]



	Annual Dental Visit (19-21 Yrs)
2013 Baseline	44.4%
DY1 Centennial Care	34.9%
DY2 Centennial Care	40.4%
DY3 Centennial Care	41.8%
DY4 Centennial Care	46.2%
2017 National Avg	36.6%

[130] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measure "adv").
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.

Exhibit 85.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 DY4, 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 85.b – Centennial Rewards for Adult Annual Dental Visits, DY1 – DY4[131]

		Cumulative DY1		Cumulative DY1-DY2		Cumulative DY1-DY3		Cumulative DY1-DY4	
Activity Group	Activity	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards
Dental	Adult Dental Visit	82,646	7.4%	152,833	19.7%	207,216	22.3%	251,763	22.5%

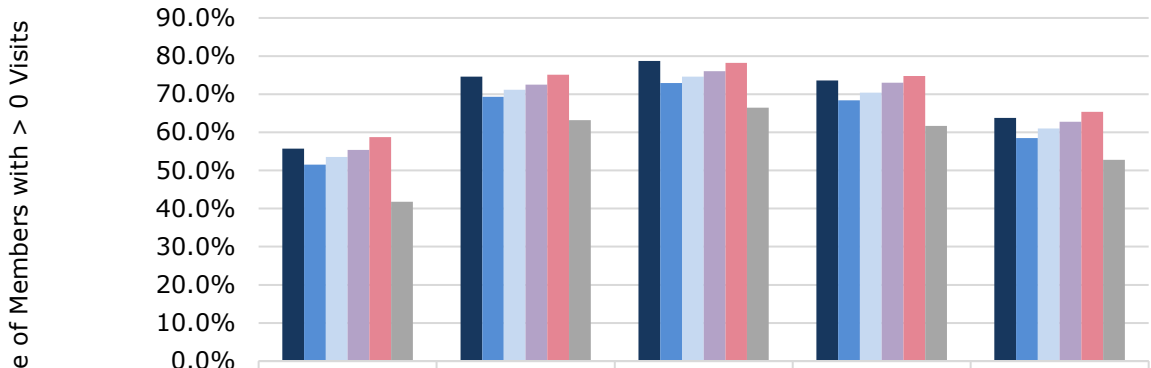
		% DY1-DY2 Change		% DY2-DY3 Change		% DY3-DY4 Change	
Activity Group	Activity	% Change in Members Earning Rewards	% Change in Redemption Rates	% Change in Members Earning Rewards	% Change in Redemption Rates	% Change in Members Earning Rewards	% Change in Redemption Rates
Dental	Adult Dental Visit	84.9%	164.4%	35.6%	13.1%	21.5%	0.9%

[131] Source: Finity 2014-2017 member rewards data.

Measure 86 – Annual dental visit – child.

Exhibit 86.a illustrates frequency of dental visits among children up to age 18 for the 2013 baseline through DY4 and the 2017 HEDIS Medicaid national average. The percentage of children receiving at least one dental visit annually increased in the range of 2.5% to 6.0% across all age cohorts from DY3 to DY4, with all age cohorts increasing in the range of 0.6% to 5.4% from the baseline to DY4 except for the 7-10 years age cohort, which experienced a decrease of 0.7%. All rates of change are statistically significant at the 95% confidence level. It is important to note that DY4 performance was above the 2017 HEDIS Medicaid national average across all age cohorts.

Exhibit 86.a – Annual Dental Visit – Child[132]



	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%
DY3 Centennial Care	55.4%	72.5%	76.0%	73.0%	62.8%
DY4 Centennial Care	58.7%	75.1%	78.2%	74.8%	65.4%
2017 National Avg	41.8%	63.2%	66.5%	61.7%	52.8%

[132] Source: MCO annual HEDIS reports for 2013 – 2017 (HEDIS Measure "adv").
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.

Exhibit 86.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 DY4. 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 86.b – Centennial Rewards for Child Annual Dental Visits, DY1 – DY4[133]

		Cumulative DY1		Cumulative DY1-DY2		Cumulative DY1-DY3		Cumulative DY1-DY4	
Activity Group	Activity	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards
Dental	Child Dental Visit	157,152	8.9%	214,036	25.7%	251,834	30.8%	279,888	32.5%

		% DY1-DY2 Change		% DY2-DY3 Change		% DY3-DY4 Change	
Activity Group	Activity	% Change in Members Earning Rewards	% Change in Redemption Rates	% Change in Members Earning Rewards	% Change in Redemption Rates	% Change in Members Earning Rewards	% Change in Redemption Rates
Dental	Child Dental Visit	36.2%	188.5%	17.7%	19.8%	11.1%	5.5%

[133] Source: Finity 2014-2017 member rewards data.

Measure 87 – Number of members spending credits.

Exhibit 87 summarizes the number of members spending credits in DY1 through DY4. Note that this exhibit provides cumulative information over the course of Centennial Care. As illustrated in the exhibit, the number of members registered, earning, and redeeming rewards all increased from DY3 to DY4; in addition the percentage of members redeeming rewards has steadily increased throughout the course of Centennial Care, which is indicative of greater member participation in the program.

Exhibit 87 – Number of Members Spending Credits[134]

Metric	DY1	DY1-DY2	DY1-DY3	DY1-DY4
Number of Members Registered in the Rewards Program	46,537	155,764	221,239	257,303
Number of Members Earning Rewards	263,336	502,448	623,581	685,460
Number of Members Redeeming Rewards	22,150	100,579	152,272	178,513
Percentage of Members Redeeeming Rewards	8.4%	20.0%	24.4%	26.0%

[134] Source: Finity 2014-2017 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 positive, and performance has generally improved since the implementation of the program.

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 reviewed 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 DY4 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 eight out of 12 measures. Improved performance was experienced in the percentage appeals upheld, partially overturned, and overturned. There were also improvements across two of three cohorts for member satisfaction with their care coordination, as well as members' overall rating of health care. There were slight improvements for the rating of personal doctors across all three cohorts and improvements across all three cohorts for the rating of specialists seen most often. Calls answered in a timely fashion also maintained high performance, however this HEDIS measure was discontinued by the NCQA after DY2.

Measure performance was mixed for how well doctors communicate and satisfaction with customer service.

Opportunities for continued improvement were identified for the remaining two process measures: percentage of expedited grievances resolved on time and percentage of grievances resolved within 30 days, both of which experienced declines only in the final year.

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 88 – Percentage of expedited appeals resolved within three business days.

Exhibit 88 presents the results for DY1 through DY4 for expedited appeals that were resolved within their allowed timeframes. The total resolution percentage decreased by 6.3% from DY3 to DY4.

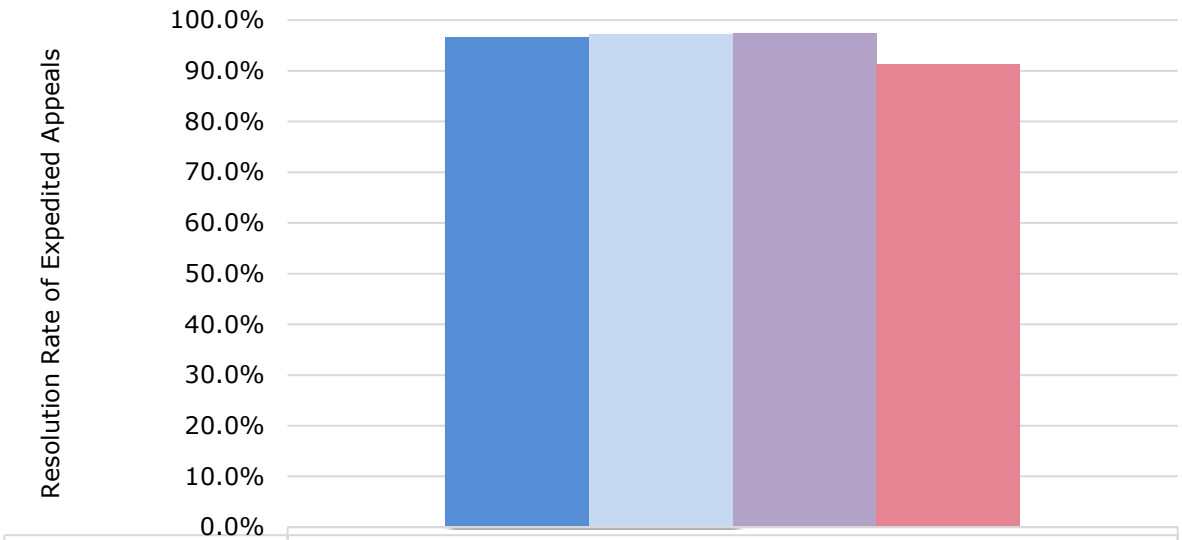
Upon review of the individual MCOs during the same reporting period, MHC experienced the greatest increase at 6.7%. BCBS decreased 25.9% which had a large impact on the overall decrease from DY3 to DY4. PHP experienced an increase of 0.8% and UHC experienced a decrease of 4.1% from DY3 to DY4.

The total resolution decreased 5.7% from DY1 to DY4. The primary driver was the substantial decrease of 29.3% experienced by BCBS. PHP and UHC experienced increases of 0.2% and 0.9% respectively, while MHC maintained consistent results from DY1 to DY4.

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[135]



DY1 Centennial Care	96.7%
DY2 Centennial Care	97.2%
DY3 Centennial Care	97.3%
DY4 Centennial Care	91.2%

[135] Source: MCO reports for 2014 – 2017 (HSD/MAD 37).
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.

Measure 89 – Percentage of grievances resolved within 30 days.

Exhibit 89 presents the results from DY1 through DY4 for grievances that were resolved within 30 days. The total resolution within 30 days decreased by 4.3% from DY3 to DY4.

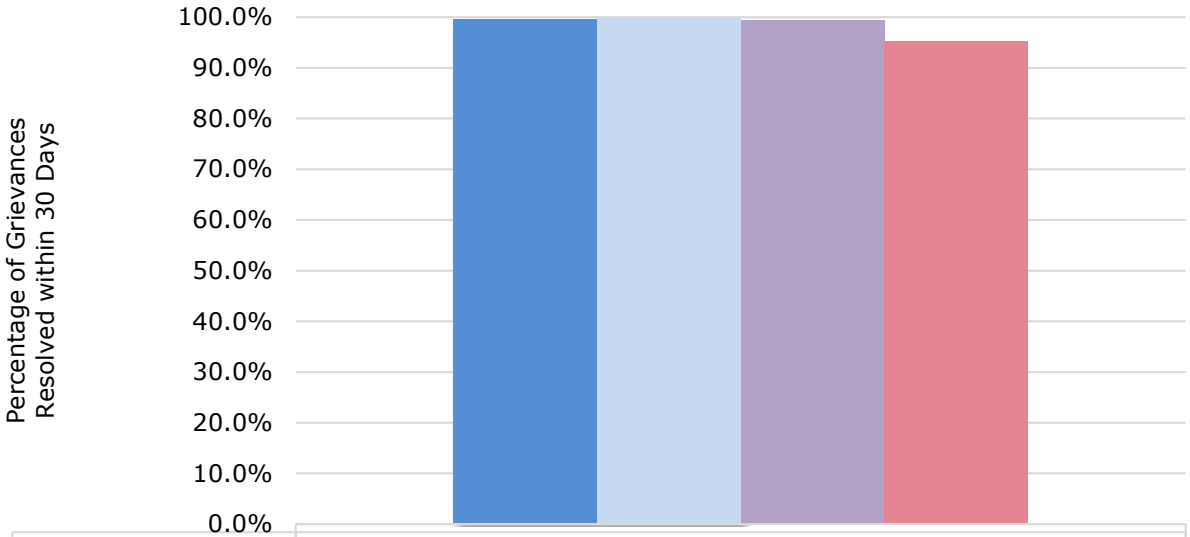
Among individual MCOs, performance was relatively consistent for MHC, PHP, and UHC from DY3 to DY4 with changes of 0.2%, -0.2%, and 0.1% respectively. BCBS experienced a substantial decrease of 27.8% which was the principal driver of the aggregate decrease from DY3 to DY4.

The total resolution within 30 days decreased 4.4% from DY1 through DY4. Consistent with the year-over-year change from DY3 to DY4, the decrease from DY1 to DY4 was driven by the decrease experienced by BCBS in DY4. Other than this isolated decrease, MCO performance in this measure has remained high throughout Centennial Care as MHC, PHP, and UHC experienced changes of 0.0%, -0.3%, and 0.3%.

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[136]



DY1 Centennial Care	99.6%
DY2 Centennial Care	99.7%
DY3 Centennial Care	99.5%
DY4 Centennial Care	95.2%

[136] Source: MCO reports for 2014 – 2017 (HSD/MAD 37).
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.

Measures 90, 91, and 92 – Percentage of appeals by adjudication (upheld, partially overturned, and overturned).

Exhibit 90 presents percentages of appeals that were upheld, partially overturned, or overturned for DY1 through DY4. The percentage of appeals upheld increased by 7.2% from DY3 to DY4, while the percentage of appeals that were partially overturned and fully overturned decreased over the same period by 30.5% and 14.3%, respectively. All four MCOs experienced directional changes for the three types of appeals that were consistent with the aggregate change from DY3 to DY4.

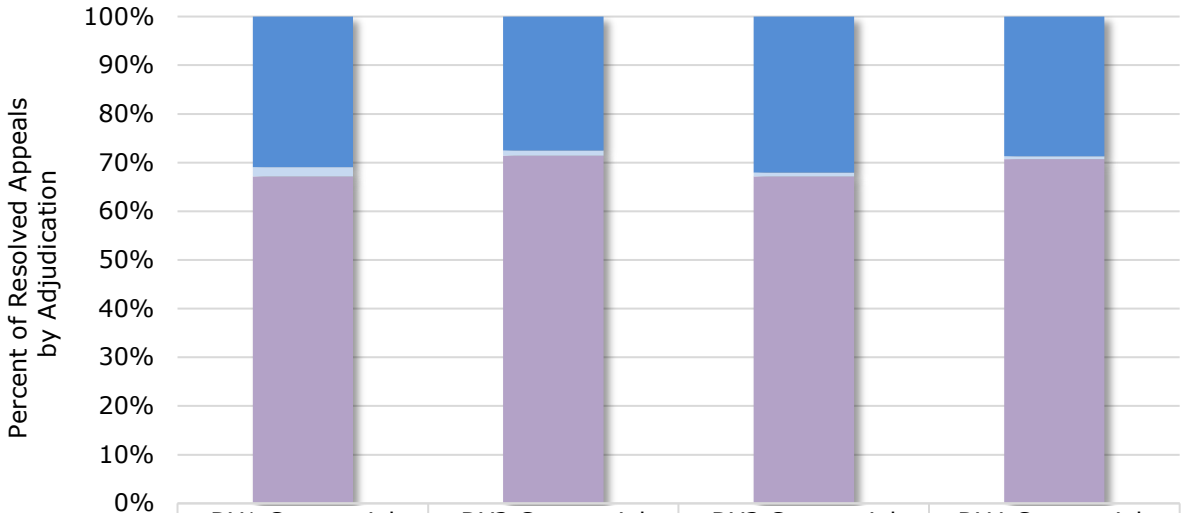
The percentage of appeals upheld also increased by 7.2% from DY1 to DY4, while the percentage of appeals that were partially overturned and fully overturned decreased over the same reporting period by 71.1% and 11.2% respectively.

Upon review of the MCOs from DY1 to DY4, UHC had the largest increase in appeals upheld at 20.6% and MHC had the largest decrease at 15.4%. BCBS and PHP experienced increases of 17.7% and 9.9% respectively. For partially overturned appeals, all MCOs experienced decreases. For fully overturned appeals, MHC had the largest increase at 39.6% while UHC had the largest decrease at 32.2% from DY1 to DY4. BCBS and PHP experienced decreases of 23.7% and 17.5% 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 90 – Appeals by Adjudication[137]



	DY1 Centennial Care	DY2 Centennial Care	DY3 Centennial Care	DY4 Centennial Care
Overturned	30.9%	27.5%	32.0%	28.7%
Partial	1.9%	1.0%	0.8%	0.6%
Upheld	67.2%	71.5%	67.2%	70.7%

[137] Source: MCO reports for 2014 – 2017 (HSD/MAD 37).
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.

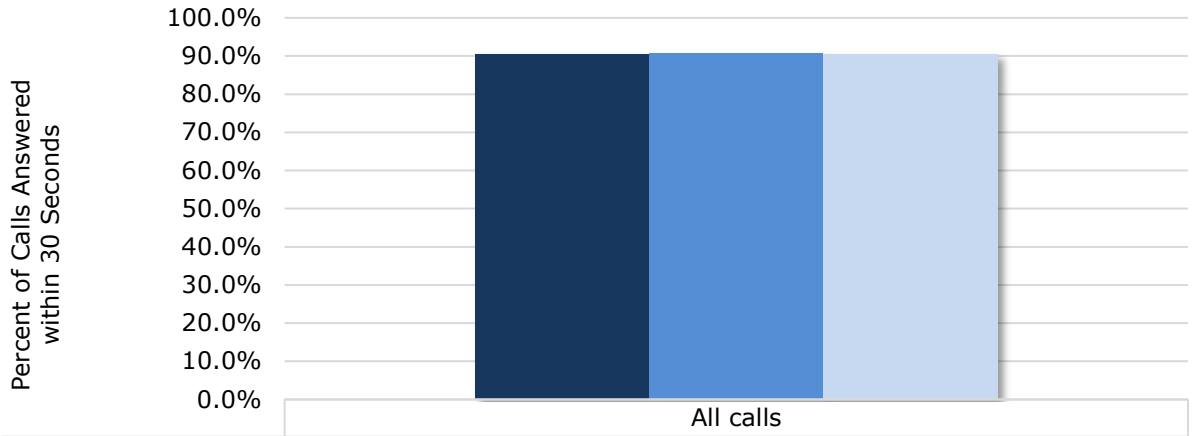
Measure 93 – Number and percentage of calls answered within 30 seconds.

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[138]



	All calls
2013 Baseline	90.6%
DY1 Centennial Care	90.7%
DY2 Centennial Care	90.4%

[138] Source: MCO Annual HEDIS Reports for 2013 – 2015 (HEDIS Measure "cat"). Note that NCQA retired the measurement of Call Timeliness in 2015.
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.

Measure 94 – Number and percentage of participants satisfied with care coordination.

Exhibit 94 presents percentages for DY2 through DY4 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) group, although it should be noted that parents/caregivers provide survey responses regarding care for children. Note that the data source for this measure changed to reflect a custom supplemental question that was added to the Centennial Care CAHPS surveys in 2015 that was more specific to care coordination satisfaction.

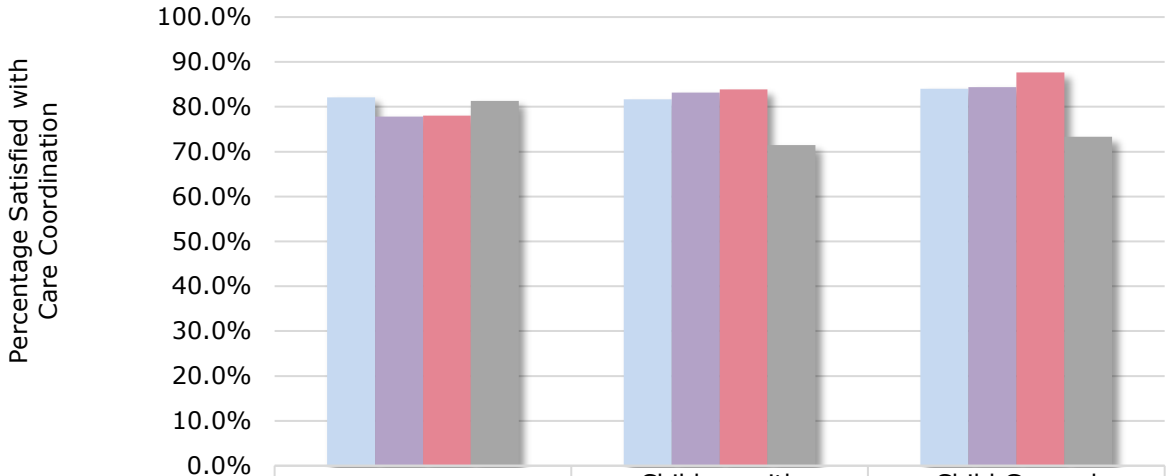
As illustrated, the percentage for satisfaction in all populations experienced increases from DY3 to DY4 with the largest increase in the children's general population at 3.8%.

For DY2 through DY4, the children's general population and children with chronic conditions both experienced percentage increases in satisfaction (4.3% and 2.7% respectively) while the adult population experienced a decrease in satisfaction at 5.0%.

Statistical significance was not calculated for this measure due to time constraints of when updated data was available for this measure.

For a national average Deloitte used the SPH Analytics benchmark percentage for all populations.

Exhibit 94 –Percentage of Participants Satisfied with Care Coordination[139]



	Adult	Children with Chronic Conditions	Child General Population
DY2 Centennial Care	82.1%	81.7%	84.0%
DY3 Centennial Care	77.9%	83.2%	84.4%
DY4 Centennial Care	78.0%	83.9%	87.6%
2016 National Avg	81.3%	71.5%	73.3%

[139] Source: MCO annual CAHPS reports for 2015 – 2017. In the Interim Report, the standard CAHPS composite measure related to Care Coordination was used as the basis of the analysis. However Centennial Care incorporated a supplemental question that was more targeted to Care Coordination satisfaction. This supplemental question was fully rolled out to all MCOs and all populations in DY2.
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.

Measure 95 – Rating of personal doctor.

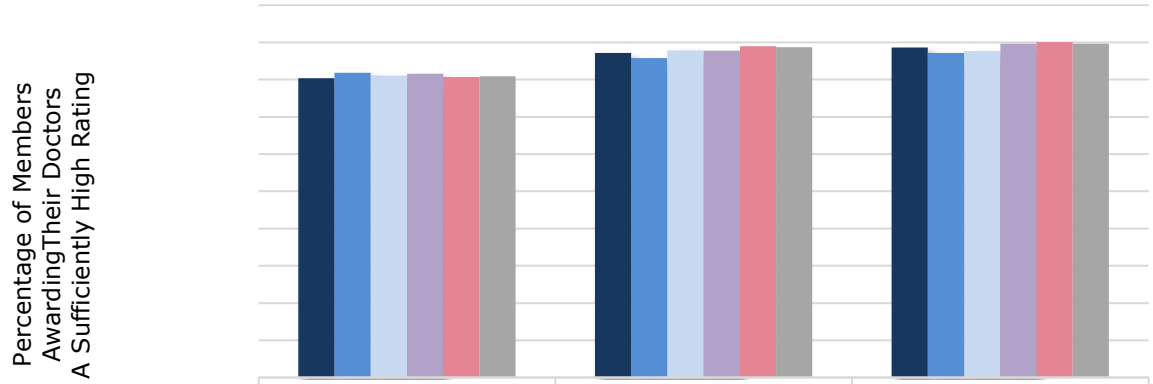
Exhibit 95 presents percentages for the 2013 baseline through DY4 and an appropriate national average comparison rate for the percentage of participants satisfied with their personal doctor. As illustrated, the satisfaction percentage increased slightly for children with chronic conditions (1%) and decreased slightly for the adult population (-1%) from DY3 to DY4. The satisfaction for the child general population remained relatively consistent between DY3 and DY4.

When analyzing the baseline to DY4 performance trends, the satisfaction percentage for all populations experienced an increase with adults and the child general population both increasing 1% and the children with chronic conditions population increasing 2%.

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 all populations.

Exhibit 95 –Percentage of Participants Satisfied with Personal Doctor[140]



	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%
DY3 Centennial Care	82%	88%	90%
DY4 Centennial Care	81%	89%	90%
2017 National Avg	81%	89%	90%

[140] Source: MCO annual CAHPS reports for 2013 – 2017.
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.

Measure 96 – Rating of health care.

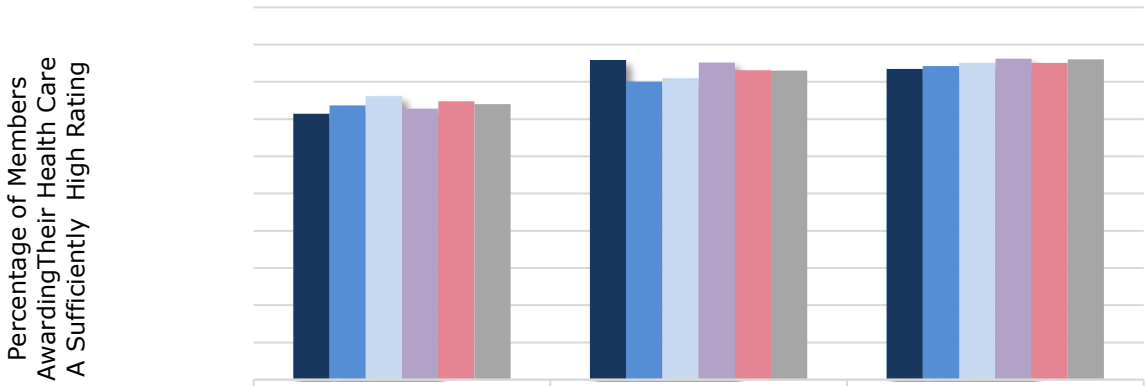
Exhibit 96 presents percentage for the 2013 baseline through DY4 and an appropriate national average for the percentage of members satisfied with their health care. As illustrated, the satisfaction percentage with health care experienced a 3% increase for the adult subcomponent from DY3 to DY4. The satisfaction percentage for the children with chronic condition population and child general population both experienced decreases of 2% and 1% respectively.

When analyzing the baseline to DY4 performance, the percentage of children with chronic condition satisfied with their health care declined (-3%), while the satisfaction percentage of the child general population and adult population increased by 2% and 6% respectively from the baseline to DY4.

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 all populations.

Exhibit 96 – Percentage of Participants Satisfied with Health Care[141]



	Adult	Children with Chronic Conditions	Child General Population
2013 Baseline	71%	86%	83%
DY1 Centennial Care	74%	80%	84%
DY2 Centennial Care	76%	81%	85%
DY3 Centennial Care	73%	85%	86%
DY4 Centennial Care	75%	83%	85%
2017 National Avg	74%	83%	86%

[141] Source: MCO annual CAHPS reports for 2013 – 2017. Note that 2013 baseline and DY1 rates have been revised from previous reports to include previously omitted data for those reporting periods.
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.

Measure 97 – Percentage of participants satisfied with how well their doctors communicate.

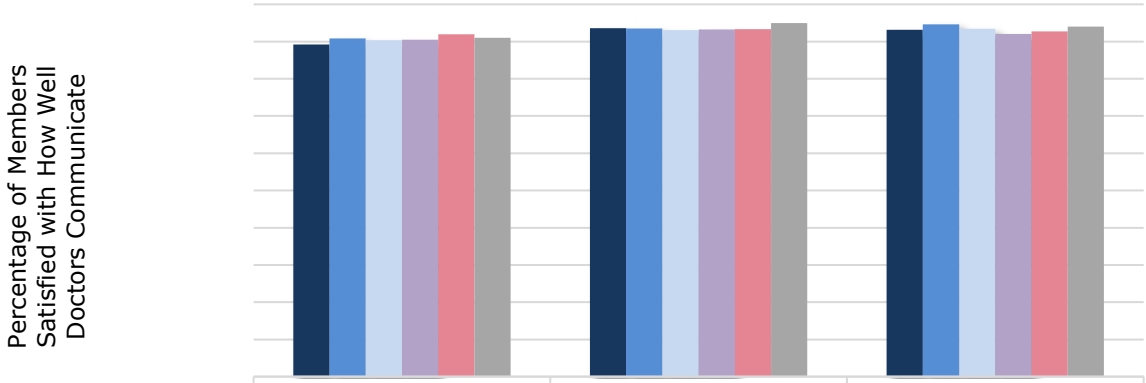
Exhibit 97 presents percentages for the 2013 baseline through DY4 and an appropriate national average for the percentage of participants satisfied with how well their doctors communicate. As illustrated, the satisfaction percentage for adults (2%) and the child general population (1%) experienced slight increases from DY3 to DY4 while the children with chronic conditions population remained relatively consistent.

When analyzing the baseline to DY4 performance, the percentage of adults satisfied with how well their doctors communicate increased 3% while the satisfaction for the children with chronic conditions population declined 1%. The satisfaction for the child general remained relatively consistent from the baseline to DY4.

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 all populations.

Exhibit 97 – Percentage of Participants Satisfied with How Well Their Doctors Communicate[142]



	Adult	Children with Chronic Conditions	Child General Population
2013 Baseline	89%	94%	93%
DY1 Centennial Care	91%	94%	95%
DY2 Centennial Care	90%	93%	93%
DY3 Centennial Care	90%	93%	92%
DY4 Centennial Care	92%	93%	93%
2017 National Avg	91%	95%	94%

[142] Source: MCO annual CAHPS reports for 2013 – 2017. Note that 2013 baseline and DY1 rates have been revised from previous reports to include previously omitted data for those reporting periods.
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.

Measure 98 – Customer service satisfaction.

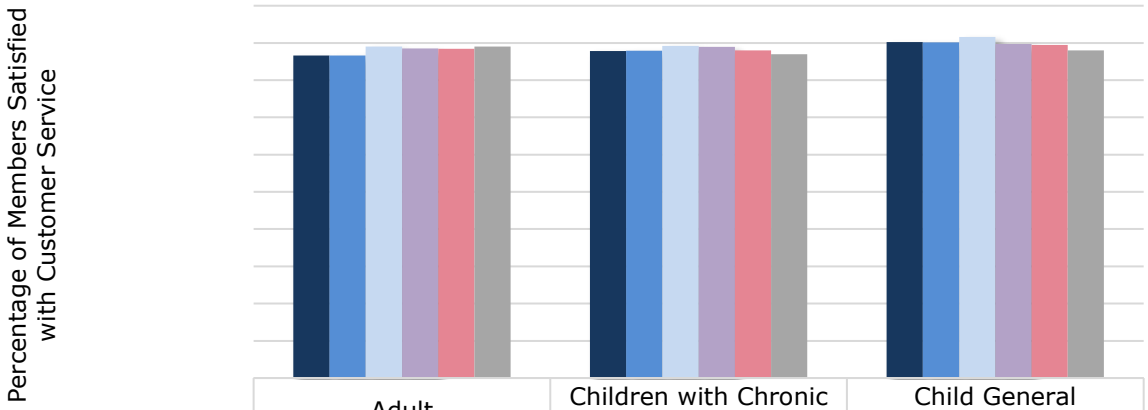
Exhibit 98 presents percentages for the 2013 baseline through DY4 and an appropriate national average for the percentage of members who were satisfied with customer service. As illustrated, customer service satisfaction percentages decreased 1% across all three populations from DY3 to DY4.

When comparing the baseline to DY4 performance trends, there were mixed results. The adult population experienced a 2% increase while the general child population experienced a 1% decrease. The children with chronic conditions population remained relatively consistent from the baseline to DY4.

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 all populations.

Exhibit 98 – Customer Service Satisfaction[143]



	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%
DY3 Centennial Care	89%	89%	90%
DY4 Centennial Care	88%	88%	89%
2017 National Avg	89%	87%	88%

[143] Source: MCO annual CAHPS reports for 2013 – 2017.
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.

Measure 99 – Rating of specialist seen most often.

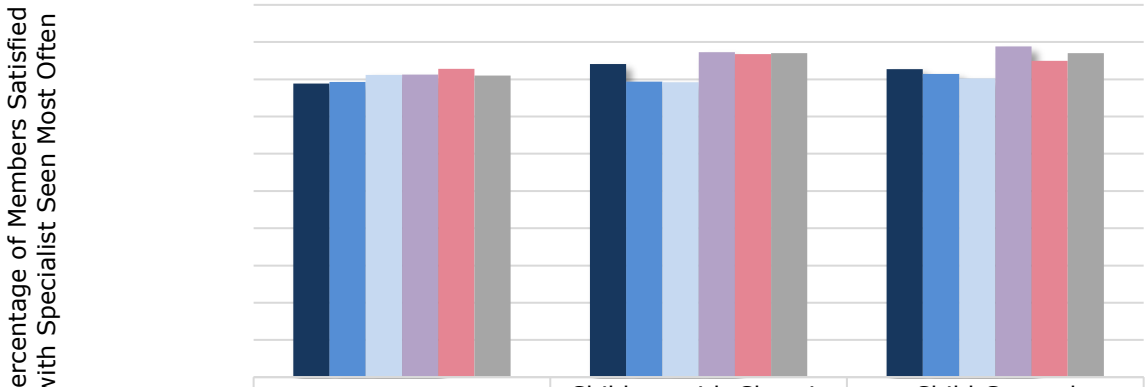
Exhibit 99 presents percentages for the 2013 baseline through DY4 and an appropriate national average for the percentage of members who were satisfied with the specialist seen most often. As illustrated, member satisfaction with specialists increased 2% among the adult population and decreased 4% among the children with chronic conditions population from DY3 to DY4. The rate for the child general population remained consistent from DY3 to DY4.

When comparing the baseline to DY4 performance, the percentage of members satisfied with their specialist increased for all categories with the largest increase experienced in adults at 5%, followed by children with chronic conditions (4%) and the child general population (2%).

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 all populations.

Exhibit 99 – Rating of Specialist Seen Most Often[144]



	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%
DY3 Centennial Care	81%	87%	89%
DY4 Centennial Care	83%	87%	85%
2017 National Avg	81%	87%	87%

[144] Source: MCO annual CAHPS reports for 2013 – 2017.
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.

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 reviewed 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 DY4 of the Centennial Care program, the MCOs continued to demonstrate high compliance rates across the measures. There was a favorable decrease in the percentage of claims denied, and high dollar accuracy rates on claims paid.

Results across subcomponents for the percentage of clean claims adjudicated remained relatively consistent or improved; the 30-day and 90-day adjudication rates declined slightly, though both rates exceeded HSD/MAD standards of 90% and 99% respectively; for claims subject to the 15/30 day standard, both subcomponents experienced increases and exceeded standards.

Declines were experienced in the percentage of grievances resolved on time and the percentage of provider appeals resolved on time, which experienced a decline in DY4 but maintained high rates throughout the rest of Centennial Care.

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.

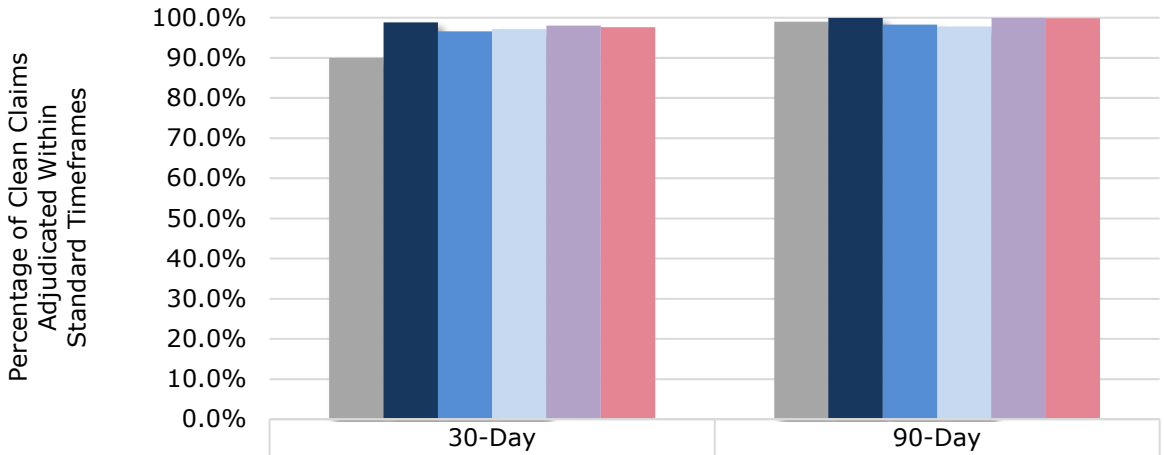
Exhibit 100.a presents the results for State Fiscal Year (SFY) 2013 through DY4 of the percentage of claims adjudicated within 30-day and 90-day standards. As illustrated, the percentages of claims resolved decreased slightly for both the 30-day and 90-day subcomponents from DY3 to DY4. Similarly, the percentages of claims adjudicated for both subcomponents experienced slight decreases from SFY 2013 to DY4.

Despite these minor decreases, both subcomponents exceeded the standards set forth, namely 90% of clean claims adjudicated within 30 days, and 99% of clean claims adjudicated within 90 days.

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[145]



	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%
DY3 Centennial Care	98.0%	99.9%
DY4 Centennial Care	97.6%	99.8%

[145] Source: Provider Payment Timeliness Report for SFY 2013; MCO reports for 2014, 2016, and 2017 (HSD/MAD 47); ad hoc claims payment and activity reports for 2015.
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.

Exhibit 100.b presents the results for DY1 through DY4 of the percentage of claims adjudicated within 15-day and 30-day standards (ITUs and Specialty provider claims). As illustrated, the percentage of claims adjudicated within the 15-day standard increased by 1.1% from DY3 to DY4 and the percentage of claims adjudicated within the 30-day standard remained relatively consistent from DY3 to DY4.

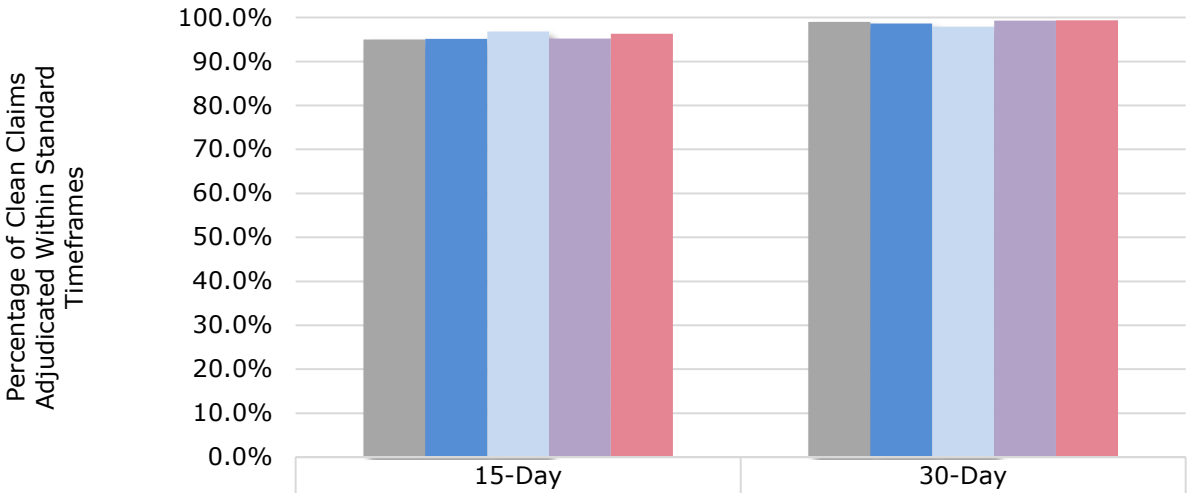
The percentage of claims adjudicated within the 15-day standard increased by 1.2% from DY1 to DY4. The percentage of claims adjudicated within the 30-day standard decreased by 0.7% over the same period.

Overall, the percentage of claims adjudicated within 15 days exceeded the standard in each year of Centennial Care and the percentage of claims adjudicated within 30 days exceeded the standard for the last two years.

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[146]



	15-Day	30-Day
HSD Standard	95.0%	99.0%
DY1 Centennial Care	95.2%	98.6%
DY2 Centennial Care	96.8%	97.9%
DY3 Centennial Care	95.2%	99.3%
DY4 Centennial Care	96.3%	99.3%

[146] Source: MCO reports for 2014, 2016, and 2017 (HSD/MAD 47); ad hoc claims payment and activity reports for 2015. 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.

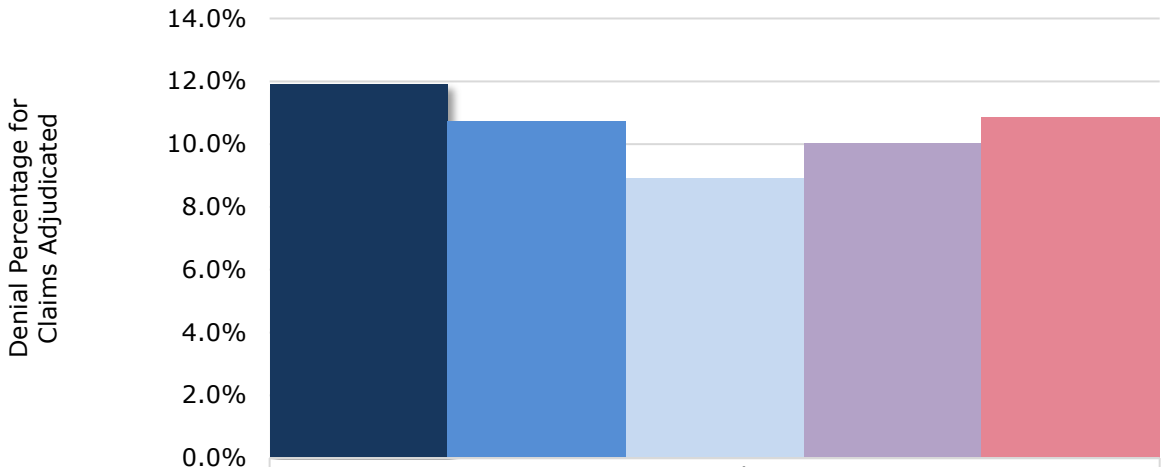
Measure 101 – Percentage of claims denied.

Exhibit 101 presents the results for SFY 2013 through DY4 of the percentage at which claims were denied. As illustrated, the percentage increased 8.4% from DY3 to DY4. However, the percentage decreased by 8.7% from SFY 2013 to DY4, a positive outcome.

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[147]



	Aggregate Denial Percentage
SFY 2013	11.9%
DY1 Centennial Care	10.7%
DY2 Centennial Care	8.9%
DY3 Centennial Care	10.0%
DY4 Centennial Care	10.9%

[147] Source: Provider Payment Timeliness Report for SFY 2013; MCO reports for 2014, 2016, and 2017 (HSD/MAD 47); ad hoc claims payment and activity reports for 2015.
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.

Measure 102 – Dollar accuracy rate.

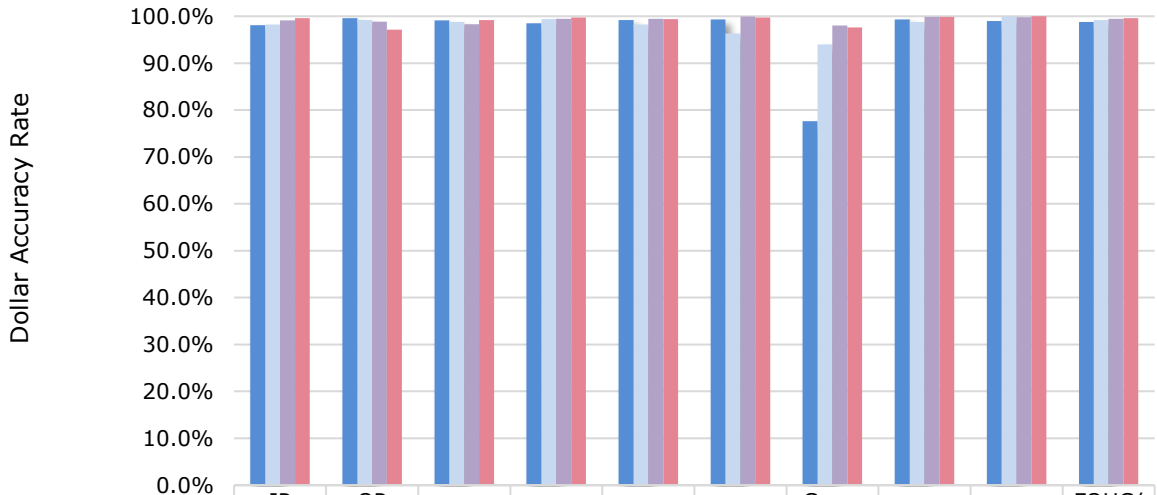
Exhibit 102 presents results for dollar accuracy rates in DY1 through DY4. For the 10 types of claims reported, six showed increases in accuracy rates from DY3 to DY4. The accuracy rate for eight of ten claim types was over 99.0%.

For nine of the ten categories, there were increases in dollar accuracy from DY1 to DY4. The largest increase was experienced in crossover claims at 25.8%. The only decrease experienced was in outpatient hospital claims at 2.5%

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[148]



	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%
DY3 Centennial Care	99.1%	98.9%	98.3%	99.5%	99.5%	99.9%	98.0%	99.8%	99.8%	99.5%
DY4 Centennial Care	99.6%	97.1%	99.2%	99.7%	99.4%	99.7%	97.6%	99.8%	100.0%	99.6%

[148] Source: MCO reports for 2014 (HSD/MAD 46); ad hoc claims payment and activity reports for 2015. 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. 2016 and 2017 data are from MCO report HSD47.
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.

Measure 103 – Percent of provider grievances resolved on time.

Exhibit 103 presents the results for DY1 through DY4 for the percentage of provider grievances resolved on time. As illustrated, from DY3 to DY4 the total percentage of grievances resolved on time decreased 16.7%

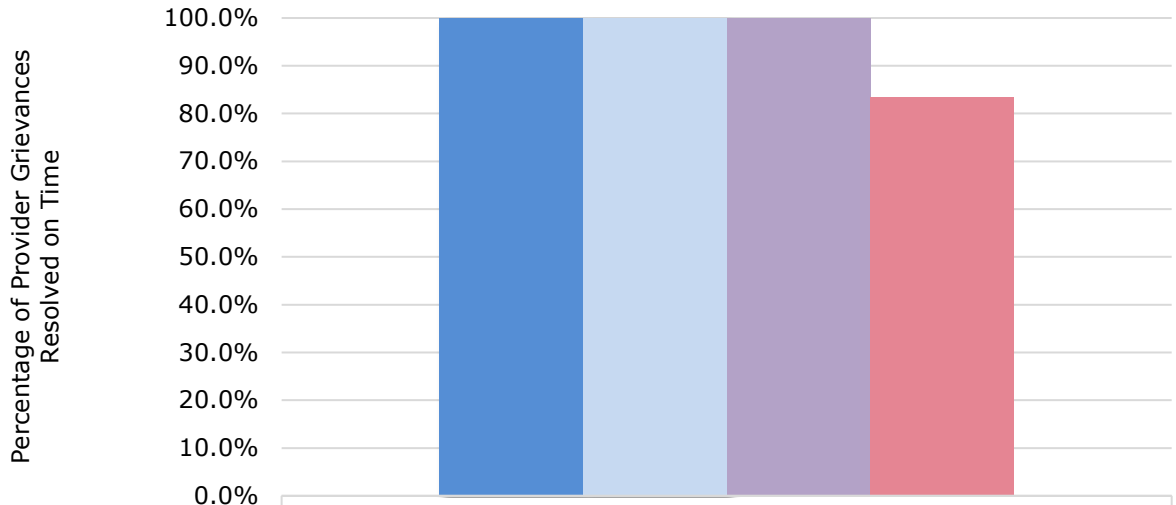
MHC, PHP, and UHC maintained consistency between DY3 and DY4 at resolving 100% of provider grievances, while BCBS experienced a decline of 60.0% from DY3 to DY4.

From DY1 to DY4, the total grievances resolved on time also decreased 16.7% due to the decrease experienced by BCBS in DY4. Despite these decreases in the most recent year, overall volume of provider grievances has been quite small throughout DY1 to DY4, ranging from 11 to 36 total annual grievances.

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[149]



	Percentage
DY1 Centennial Care	100.0%
DY2 Centennial Care	100.0%
DY3 Centennial Care	100.0%
DY4 Centennial Care	83.3%

[149] Source: MCO reports for 2014 – 2017 (HSD/MAD 37).
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.

Measure 104 – Percentage of provider appeals resolved on time.

Exhibit 104 presents results for DY1 through DY4 for the percentage of provider appeals resolved on time. As illustrated, the total provider appeals resolved on time decreased 12.0% from DY3 to DY4.

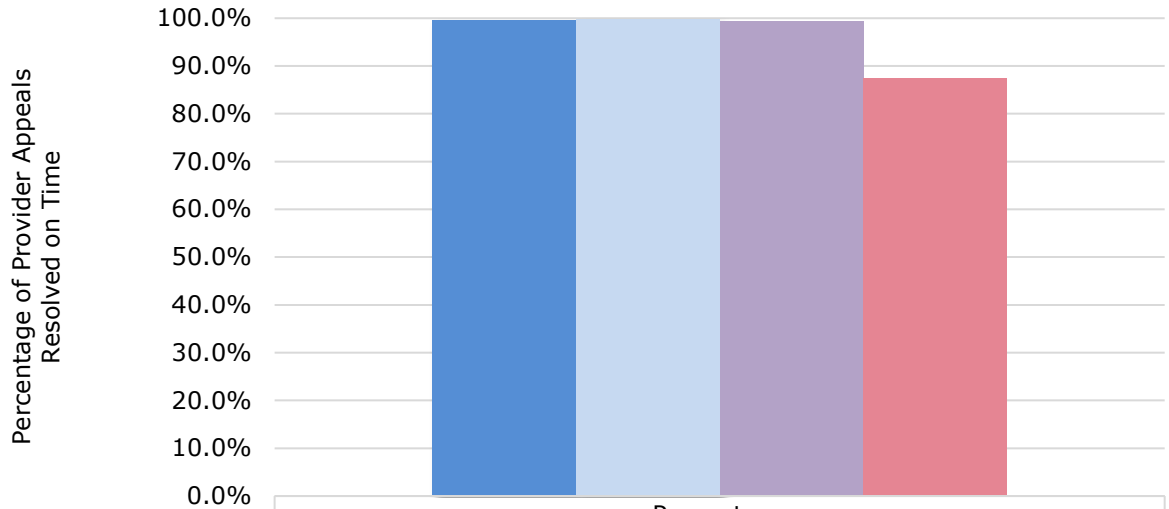
PHP maintained relatively consistent results from DY3 to DY4, but BCBS, MHC, and UHC experienced declines of 54.2%, 8.2%, and 2.5% respectively.

The percentage of total provider appeals resolved on time decreased 12.2% from DY1 to DY4. This was driven by the decreases experienced by BCBS and MHC of 58.4% and 8.2% respectively. PHP maintained consistent results and UHC experienced a slight decrease of 1.5% from DY1 to DY4.

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[150]



	Percentage
DY1 Centennial Care	99.5%
DY2 Centennial Care	99.6%
DY3 Centennial Care	99.3%
DY4 Centennial Care	87.4%

[150] Source: MCO reports for 2014 – 2017 (HSD/MAD 37).
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.

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 DY4 of the Centennial Care program, progress continued 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, although 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 Patient Centered Medical Home (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 2017 of the number of hospitals that received EHR payments.

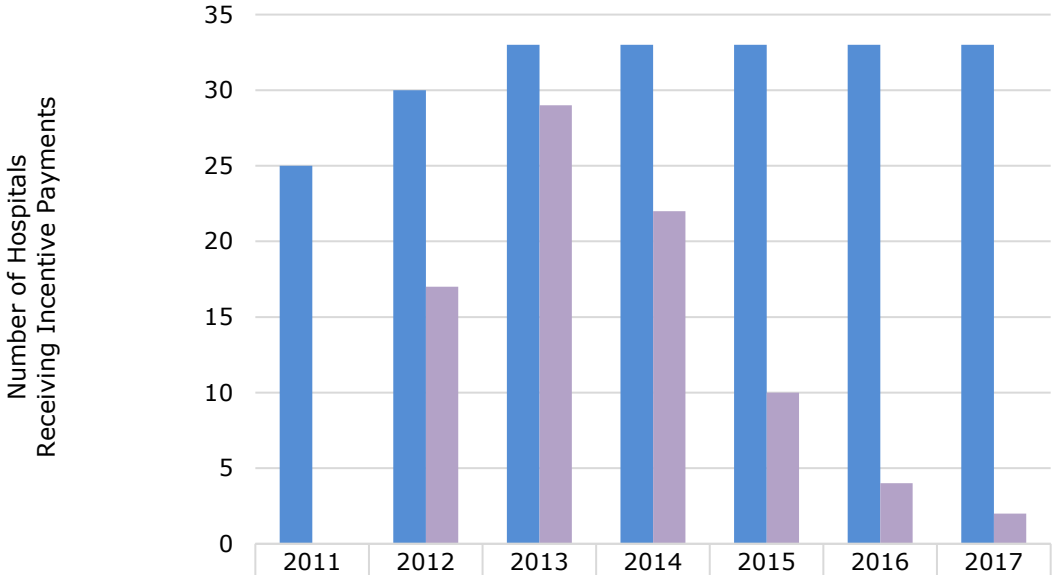
The number of initial hospital payments did not increase from 2016 to 2017. These payments are only available to new participants in their first year of the program and may not be received more than once. This year-to-year stability in the cumulative payments suggests that all hospitals interested in 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 decreased by 2 payments, a 50.0% decrease from 2016 to 2017. This is not necessarily a negative development, as hospitals may only receive EHR payments for three years before they are no longer eligible. Over 84% of the meaningful use payments that could possibly be made, based on the number of hospitals 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[151]



	2011	2012	2013	2014	2015	2016	2017
Initial Payment (cumulative)	25	30	33	33	33	33	33
Meaningful Use Payment (per year)		17	29	22	10	4	2

Exhibit 106.b presents the number of professional providers that received incentive payments from 2011 to 2017.

[151] Source: HSD/MAD ad hoc reports for 2014 – 2017. Initial payment data updated to reflect most currently available information. 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.

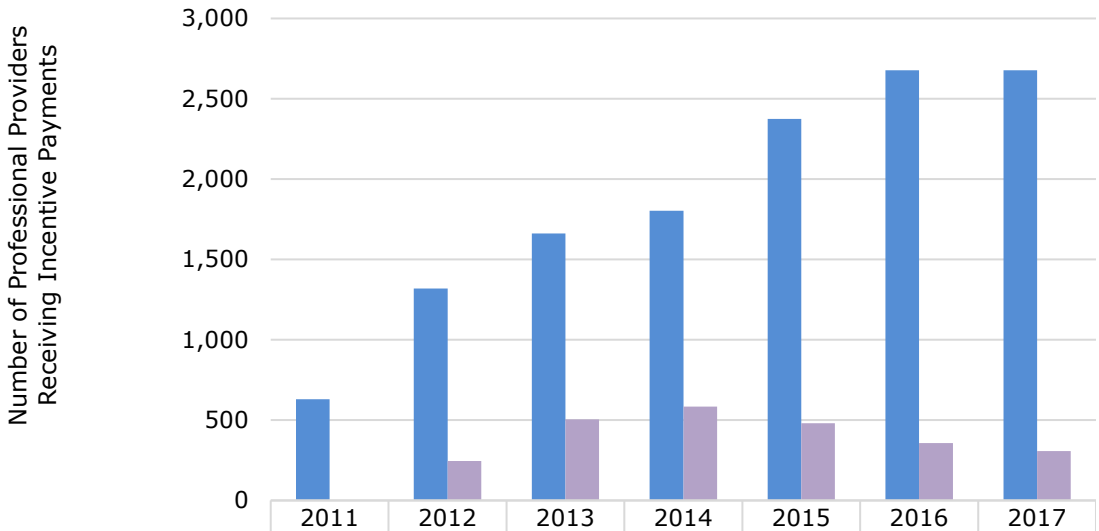
There was no change in the number of initial payments made to eligible professionals from 2016 to 2017. Similar to the hospital payments, there are limitations on the EHR payments. Each provider may receive an initial payment once, so a decrease in the number of providers receiving those payments may 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 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. Going forward, providers can no longer start the program or attest after 2016 which accounts for the numbers remaining constant at the end of 2017.

The number of meaningful use payments decreased 14.1% from 2016 to 2017. 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 to receive incentive payments and therefore reflects 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. Additionally, providers can no longer start the program after 2016 which accounts for no new activity.

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[152]



	2011	2012	2013	2014	2015	2016	2017
Initial Payment (cumulative)	629	1,319	1,662	1,804	2,375	2,677	2,677
Meaningful Use Payment (per year)		245	504	585	480	357	307

[152] Source: HSD/MAD ad hoc reports for 2014 – 2017.
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.

Measure 108 – Percentage of claims paid accurately.

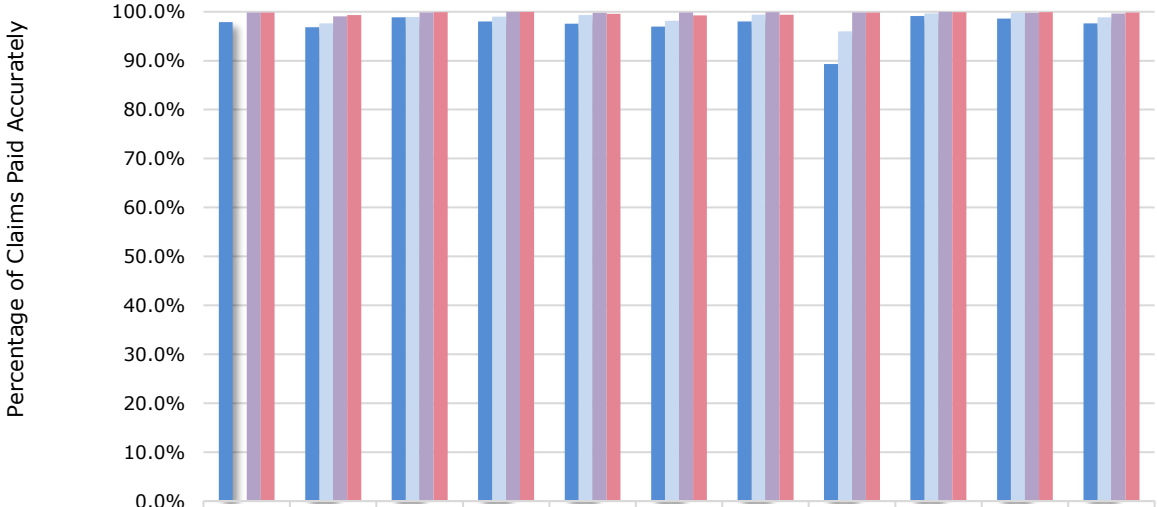
Exhibit 108 presents results for DY1 through DY4 of the percentage of claims paid accurately. The percentage of claims paid accurately among claim types relatively consistent from DY3 to DY4, with all subcomponents maintaining an accuracy rate greater than 99.0%.

All ten categories experienced increases in accuracy rates from DY1 to DY4 with the largest increase experienced for crossover claims at 11.8%, which are a particularly difficult category for adjudication.

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[153]



	All	IP Hosp	OP Hosp	Prof	BH	NF	I/T/U	Cross over	HCBS	Dental	FQHC/ RHC
DY1 Centennial Care	97.9%	96.9%	98.8%	98.0%	97.5%	97.0%	98.0%	89.3%	99.1%	98.6%	97.6%
DY2 Centennial Care	0.0%	97.6%	98.9%	99.0%	99.3%	98.2%	99.4%	96.0%	99.7%	99.8%	98.9%
DY3 Centennial Care	99.9%	99.0%	99.8%	100.0%	99.8%	99.8%	99.9%	99.9%	100.0%	99.8%	99.7%
DY4 Centennial Care	99.8%	99.3%	99.9%	100.0%	99.6%	99.2%	99.4%	99.8%	99.9%	99.9%	99.8%

[153] Source: MCO reports for 2014 (HSD/MAD 46); ad hoc claims payment and activity reports for 2015. 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. DY3 and DY4 data from MCO reports (HSD/MAD 47).
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.

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 through DY4 for a 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.).

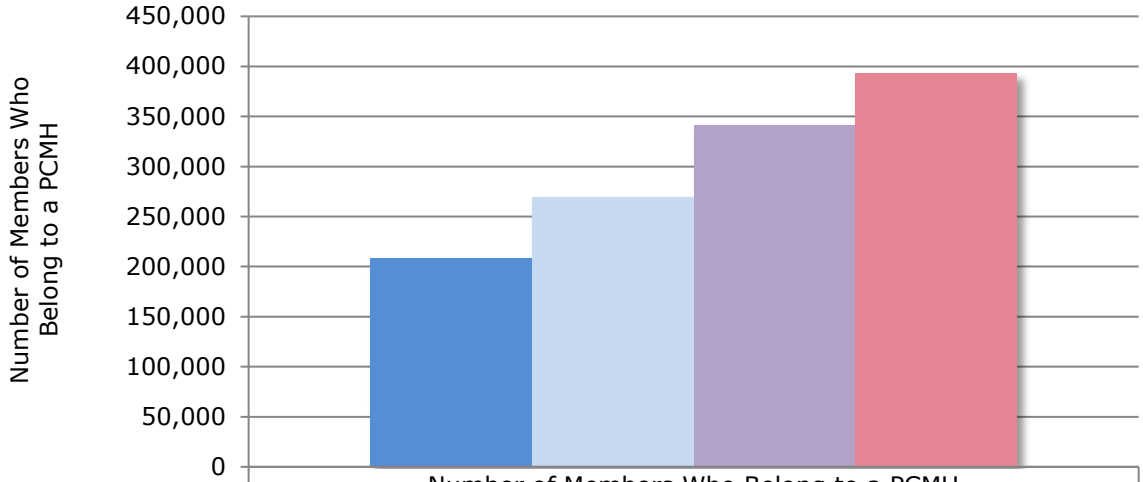
As illustrated, the number of members who belong to a PCMH increased by 15.0% from DY3 to DY4. The number of members who visited the emergency department one time during the reporting period was the only category that experienced an increase (19.3%) during the same reporting period. The largest decrease experienced was in the number of members who visited the emergency department four or more times during the reporting period (-32.7%).

From DY1 to DY4, the total number of members who belonged to a PCMH increased by 88.6%. The number of members who visited the emergency department four or more times during the reporting period experienced the largest increase from 1.3% to 3.3% (a 154.6% increase) during the same reporting period. The largest decrease was experienced in the number of members who belong to a PCMH who were readmitted to a hospital within 30 days of a pervious hospital admission (-39.7%).

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.

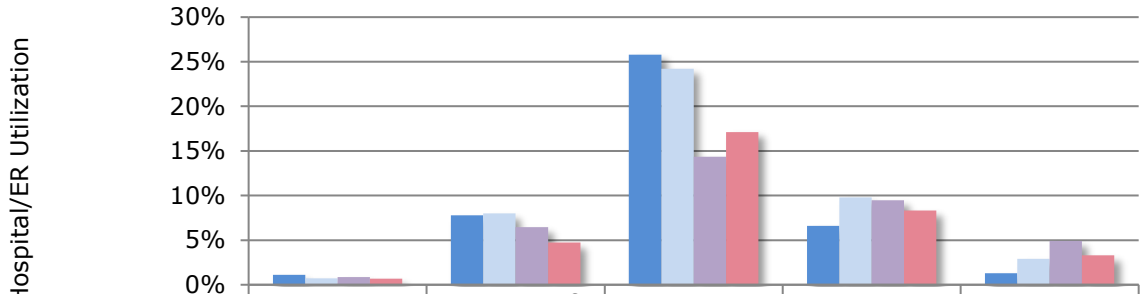
Exhibit 109.a – Number of Members who Belong to a PCMH[154]



	Number of Members Who Belong to a PCMH
DY1 Centennial Care	208,174
DY2 Centennial Care	268,840
DY3 Centennial Care	341,406
DY4 Centennial Care	392,614

[154] Source: MCO reports for 2014 – 2017 (HSD/MAD 48).
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.

Exhibit 109.b – PCMH Membership Hospital/ER Utilization[155]



	Percent of PCMH members readmitted to hospital within 30 days	Percent of members paneled to a PCMH who have been seen at PCMH site within 7 days following a hospital admission or ED visit	Percent of members who visited ED 1 time during the reporting period	Percent of members who visited ED 2-3 times during the reporting period	Percent of Members who visited ED 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%
DY3 Centennial Care	0.8%	6.5%	14.3%	9.5%	4.9%
DY4 Centennial Care	0.7%	4.7%	17.1%	8.3%	3.3%

[155] Source: MCO reports for 2014 – 2017 (HSD/MAD 48).
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.

Conclusion

The Centennial Care 1115 Waiver program has met the majority of designated goals to date. This is particularly noteworthy given the significant influx of new members that occurred shortly after program implementation. The vast majority of this increase was driven by the Medicaid expansion group, which grew by 66.5%.

Major Centennial Care program goals included 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 noted improved progress in timely access to care across a wide range of measures as compared to the baseline of the Centennial Care program. Increases were found in the percentage of state population enrolled in Centennial Care and the percentage of Native Americans opting into Centennial Care, indicating that those eligible for benefits are continuing to enroll. There was improvement in the ratio of members to providers, increased access to telemedicine and use of mental health services (as indicated by members' principal diagnosis)[156], immunization rates for adolescents, the percentage of members utilizing newly available BH services (BH respite, family support, and recovery services), and maintenance of high performance for annual dental visits.

  Conversely, declines were found in the percentage of adult members accessing preventive/ambulatory services, although the DY4 aggregate rate increased in a statistically significant fashion from DY3, the percentage of adult and children members who had a PCP visit and the percentage of PCPs with open panels (though the overall percentage of open panels remained above 90% for three of four years), various preventive measures such as screening rates for breast cancer and cervical cancer, immunization rates among children, adolescent well care visits, and prenatal and postpartum care. These declines represent potential areas for continued focus in coming years, and in some cases were potentially affected by external factors such as the expansion of Medicaid and the continued influx of new members.

- **Improving Care Coordination –** The Evaluation documented general progress in care coordination activities. Improvements were noted in the percentage of members in Care Coordination Level 2 and 3 for whom a CNA was performed, there was a favorable decline in the percentage of ER visits that were potentially avoidable among members in Care Coordination Levels 2 and 3, and member satisfaction with care coordination has also increased over the course of Centennial Care.

  There has been an increase in the number of unique members with BH needs receiving HCBS, and an overall increase in HCBS provided among all members. New Mexico continues to be successful in its rebalancing efforts with 85.6% of long-term care members receiving long-term services in their homes and 14.4% of members residing in nursing facilities.

- **Improving Care Integration** – The Evaluation noted mixed progress in care integration activities. Improvements were noted in the percentage of LTSS members who also utilized a BH service, and a favorable decline in the ER visit rates among members with BH needs. The percentage of members accessing a BH service that also received an outpatient ambulatory visit in the same year remained relatively consistent.

[156] This HEDIS measure is based on the Mental Health Value Set, which does not include diagnoses or services related to Substance Use Disorders.

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

- **Improving Quality of Care –** The Evaluation found continued improvements in quality of care. There were improvements in monitoring rates of BMI for adults, children, and adolescents, and increases in asthma medication management and medication ratios. Hospital admission rates also decreased across all six ACS components: hypertension, pediatric asthma, diabetes admissions related to short term and long-term complications, and COPD/asthma in older adults and younger adults. Finally, there was a decline in the percentage of potentially avoidable ER visits.

  Conversely, performance declined for EPSDT screening ratios (although results exceeded national averages), smoking and tobacco use cessation, annual patient monitoring for persistent medications, and the number of critical incidents.

- **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 DY4. Total program expenditures for DY4 alone were 28.1% below the budget-neutral limits as defined by the STCs, which includes PMPM cost caps by MEG, uncompensated care costs, and Hospital Quality Improvement Incentive (HQII) pool amounts. The total PMPM costs of Centennial Care have also decreased in absolute terms from DY1 to DY4, declining 4% across all MEGs.

  Program savings were driven in part by the transition to less costly services, including greater utilization of outpatient substance abuse, an increase in the use of HCBS (e.g. rebalancing of LTSS), positive shifts in pharmacy utilization where usage of generic drugs is more prevalent than brand drugs, and continued reduction in inpatient claims exceeding $50,000 as a percentage of healthcare costs.

  The Evaluation noted unfavorable increases in all cause readmissions and ER utilization, as well as slight unfavorable increases in diagnostic imaging costs and hospital costs.

- **Increased Member Engagement** – There was a significant increase in the number of members who enrolled in the Centennial Rewards program and performed 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. As of Q3 of DY4, approximately 245,000, or 26.2% of eligible members were registered for the program. In addition, the percentage of eligible members earning rewards was just over 40% through DY1 but increased to over 72% by DY4. 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 DY4.

- **Increased Member Satisfaction –** The Evaluation found that member satisfaction results largely improved through DY4 and improved since Interim reporting. Centennial Care members experienced improvements in the rating of personal doctors, rating of specialists seen most often, and the rating of health care. There were also improvements in the percentage of appeals upheld, partially overturned, and overturned (favorable decline). Satisfaction rates for care coordination and customer service also increased for members from the baseline to DY4.

- **Implementing New Processes and Technologies** – The three process and technology measures for which there are sufficient data showed improved results through DY4. 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. Incentive payments for EHR use also demonstrated hospital and provider engagement in technology-enabled solutions for enhancing care coordination and reducing duplicative services by means of shared EHR data.

In conclusion, the Centennial Care waiver demonstration has driven health care system reform in New Mexico and has made significant progress in achieving the goals and proving the related hypotheses set forth in the Evaluation Design Plan.

There is also continued opportunity for improvement, as documented in this report. The State and MCOs are encouraged to use the Evaluation findings to identify priority areas for program enhancement under the upcoming Centennial Care 2.0 renewal period to achieve continually positive outcomes.

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 DY4	HSD/MAD 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 DY4	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/MAD 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/MAD 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 frontier areas. At least five percent*	Baseline through DY4	For the 2013 baseline rate, HSD/MAD 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. For the DY1 through DY4 counts, HSD/MAD again furnished telemedicine visit data obtained through

Measure	Measure Name	Definition	Evaluation Methodology	
		(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.		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 account the resources available to the public entity and the needs of others	Baseline to DY4	For both NF and HCBS rates for all years, Deloitte was provided with rates by HSD/MAD 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 the State's actuary.

Measure	Measure Name	Definition	Evaluation Methodology	
		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 DY4	For the Baseline calculation, HSD/MAD 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/MAD 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. For the national comparison rate, a 2017 National Medicaid HMO rate as reported by the National

Measure	Measure Name	Definition	Evaluation Methodology	
				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 population estimates are from the U.S. Census Bureau.	DY1 through DY4	HSD/MAD furnished Deloitte with statewide analyses developed by the State's actuary 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	
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/MAD 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 members at a point in time. December was the most appropriate month because it is furthest in time from the commencement of services.	DY1 to DY4	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/MAD furnished Deloitte with the monthly reports submitted by the four Centennial Care plans in DY1 through DY4. 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	
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/MAD 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 DY4	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/MAD 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 DY4	HSD/MAD 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 members to providers	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 the provider network to provide services.	DY1 to DY4	HSD/MAD furnished Deloitte with quarterly HSD/MAD 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 four to arrive at an average annual number of providers as the denominator. The numerator was member months from the State's actuary dashboard data that supports Measure 7, divided by twelve to arrive at the average annual members.

Measure	Measure Name	Definition	Evaluation Methodology	
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/MAD requires Centennial Care plans to report quarterly on the number of PCPs with open and closed panels.	DY1 to DY4	HSD/MAD furnished Deloitte with quarterly HSD/MAD 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/MAD 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 DY4	HSD/MAD 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 DY4	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/MAD 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/MAD 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 DY4	HSD/MAD 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/MAD 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 DY4	HSD/MAD 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 DY4	HSD/MAD 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 through 2017. 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 through 2017.

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 DY4	HSD/MAD furnished Deloitte with audited HEDIS data for three MCOs (UHC did not report on this measure) in 2013, and four MCOs in 2014 through 2017. 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 through 2017.
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 DY4	HSD/MAD 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 through 2017.

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 DY4	HSD/MAD 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 DY3	HSD/MAD 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. Note that the NCQA discontinued this measure after reporting year 2016 (DY3).

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.	Baseline to DY4	HSD/MAD 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.	Baseline to DY1, DY4	HSD/MAD 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 to DY3	HSD/MAD 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 DY4	HSD/MAD furnished Deloitte with CAHPS reports containing survey results for samples of the adult population where adults indicated whether they had received a flu vaccination or nasal spray.
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 timeliness of substance abuse treatment services for Centennial Care members.	DY1 to DY4	No MCO reported on this measure in 2013, and thus 2014 data is used as the baseline. HSD/MAD furnished Deloitte with audited HEDIS data for three MCOs (UHC did not report on this measure in DY1 or DY2) in each year. Deloitte combined the applicable 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	
27	Geographic Access Measures	"Geographic Access Measures" is a measure developed by HSD/MAD as a way to evaluate access to primary care for Centennial Care enrollees across the State of New Mexico. HSD/MAD 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 DY4	HSD/MAD furnished Deloitte with HSD/MAD 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.
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/MAD 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/MAD reports, including "within contract timelines." An alternative definition was developed to align the intent of the Evaluation Plan with the information available in HSD/MAD Care Coordination Report 6 and future ad hoc reports: The "Number and Percentage of	DY3 to DY4	HSD/MAD furnished Deloitte with ad hoc MCO reports containing annual counts of Level 2 assignments given and CNAs completed during the quarter. Numerators and denominators were developed by summing the annual counts across MCOs.

Measure	Measure Name	Definition	Evaluation Methodology	
		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/MAD 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/MAD reports, including "within contract timelines." An alternative definition was developed to align the intent of the Evaluation Plan with the information available in HSD/MAD 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.	DY3 to DY4	HSD/MAD furnished Deloitte with ad hoc MCO reports containing annual counts of Level 3 assignments given and CNAs completed during the quarter. Numerators and denominators were developed by summing the annual counts across MCOs.

Measure	Measure Name	Definition	Evaluation Methodology	
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/MAD 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 intent of the Evaluation Plan with the information available in HSD/MAD 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/MAD 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".	DY1 to DY4	HSD/MAD furnished Deloitte with HSD/MAD 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.
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/MAD 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	DY3 to DY4	HSD/MAD furnished Deloitte with ad hoc MCO reports containing annual counts of members that refused care coordination services from the MCOs. Numerators and denominators were developed by summing the annual counts across MCOs.

Measure	Measure Name	Definition	Evaluation Methodology	
		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.		
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	FFY 2013 Baseline to FFY 2017	HSD/MAD 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 2017 was used.

Measure	Measure Name	Definition	Evaluation Methodology	
		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.		
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	Baseline to DY4	HSD/MAD 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	
		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 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 DY4	HSD/MAD 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.
40	Asthma medication ratio	"Asthma Medication Ratio" is a HEDIS measure that reports the percentage of	Baseline – DY4	HSD/MAD furnished Deloitte with HEDIS data for the four MCOs. Deloitte combined the four plans'

Measure	Measure Name	Definition	Evaluation Methodology	
		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 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.		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.
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.	Baseline to DY4	HSD/MAD 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	
		Obesity ranges are determined by using a commonly used weight-for-height screening tool called the "BMI", which 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 DY4	HSD/MAD 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/MAD 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 DY4	HSD/MAD 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/MAD 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 DY4	HSD/MAD 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/MAD 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 DY4	For DY1 to DY2, HSD/MAD 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 DY4	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 symptoms of sufficient severity (including severe pain) such that a	DY1 to DY4	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/MAD furnished Deloitte with MCO reports (HSD/MAD 40: Over-Under Utilization Report) submitted by three of the four MCOs (MHC did not have reportable data in 2014 or 2015). Note that in DY4 two MCOs reported using ad hoc reports as the standard HSD40 report had been discontinued. The reports covered the four quarters of their respective calendar years 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	
		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/MAD 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 DY4	HSD/MAD 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 unknown origin, death, environmental hazard, which involve some level of	DY1 to DY4	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/MAD furnished Deloitte with summarized data of 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	
		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 functioning and well-being, and can reduce the risk of suicide. With proper management of depression, the overall	Baseline to DY4	HSD/MAD furnished Deloitte with audited HEDIS data for the four MCOs (note one plan did not report in the baseline period). 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	
		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/MAD 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 DY4	For DY1 through DY4, HSD/MAD 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 claims 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 high or low nursing facility services	DY1 to DY4	The MCOs did not report on this measure in 2013. Therefore, 2014 data is utilized as the baseline. HSD/MAD 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	
		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 DY4	HSD/MAD furnished Deloitte with ad hoc reports created by the state's actuary 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/MAD 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 DY4	For DY1 through DY4, HSD/MAD 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/MAD 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 DY4	For DY1 through DY4, HSD/MAD 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/MAD 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 DY4	For DY1 through DY4, HSD/MAD 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 DY4	HSD/MAD 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 DY4	HSD/MAD 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 and also from a cost-effectiveness perspective for the state.	Baseline	For the baseline calculation, HSD/MAD furnished Deloitte with the HSD/MAD Medical Assistance Division (MAD) Fourth Quarter SFY 14 HSD/MAD 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	
		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 through DY2, HSD/MAD furnished Deloitte with the HSD/MAD Medical Assistance Division (MAD) Fourth Quarter SFY 15 HSD/MAD 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. Note that HSD/MAD retired this measure after DY2 as members are no longer required to enter a NF in order to receive NF LOC services.
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/MAD 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 DY4	For DY1 through DY4, HSD/MAD 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 meet the requirements for CCL2 during the monthly reporting period	DY1 to DY4	HSD/MAD 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	
		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.		
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	Baseline	For the baseline calculation, HSD/MAD 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.

Measure	Measure Name	Definition	Evaluation Methodology	
		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.	DY1 to DY4	For DY1 through DY4, HSD/MAD 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 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	Baseline to DY4	HSD/MAD 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	
		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. 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.	Baseline to DY4	HSD/MAD 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	
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/MAD 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/MAD 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 DY4	The total program costs for each year as provided in the CMS-64 Schedule C reports and Budget Neutrality reports.
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 DY4	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.

Measure	Measure Name	Definition	Evaluation Methodology	
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/MAD 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.
			DY1 to DY4	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 PH, BH, and LTSS.	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 DY4	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 hospital, clinic, and facility visits. The	Baseline	The costs across various categories related to hospitals, clinics, and facilities, as well as member months, were reported in quarterly MCO financial submissions. These reports only contain information for membership under managed care

Measure	Measure Name	Definition	Evaluation Methodology	
		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		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 DY4	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 DY4	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 DY4	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 DY4	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 DY4	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 DY4	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 DY4	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/MAD 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 DY4	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.
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

Measure	Measure Name	Definition	Evaluation Methodology	
				the first quarter of 2014, and scaled to an annual units per 1,000 basis by multiplying by 12,000.
			DY1 to DY4	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.
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 DY4	HSD/MAD furnished Deloitte with all cause readmission rates calculated by the state's actuary using MMIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate 2014 rate.

Measure	Measure Name	Definition	Evaluation Methodology	
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 DY4	HSD/MAD 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 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	Baseline	HSD/MAD 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.
			DY1 to DY4	HSD/MAD 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/MAD 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,

Measure	Measure Name	Definition	Evaluation Methodology	
		year for refilling their child's asthma as prescribed.		and number of members redeeming rewards in DY1 through DY4.
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 DY4	HSD/MAD 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/MAD 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 through DY4.

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 DY4	HSD/MAD 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/MAD 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 through DY4.

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 DY4	HSD/MAD 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/MAD 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 through DY4.
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	DY1 to DY4	HSD/MAD 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 through DY4.

Measure	Measure Name	Definition	Evaluation Methodology	
		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.		
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 DY4	HSD/MAD provided an MMIS data extract for calendar years 2013 through 2017 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/MAD 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 through DY4.

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 DY4	HSD/MAD 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/MAD 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 through DY4.
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 DY4	HSD/MAD 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/MAD 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 through DY4.

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 DY4	HSD/MAD 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 through DY4.
88	Percentage of expedited appeals resolved within three business days	HSD/MAD 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)…"*[157][158] The New Mexico Human Services Department (HSD) requires MCOs to track and report on appeals and grievance activity on a monthly	DY1 to DY4	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/MAD 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.

[157] Contractors may request an extension from HSD/MAD in accordance with 42CFR Section 438.408(c).
[158] Centennial Care Contract, Section 4.16.3 – Expedited Resolution of Appeals.

Measure	Measure Name	Definition	Evaluation Methodology	
		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/MAD 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."*[159] HSD/MAD also defines the allowable time period for resolution of grievances. Specifically:	DY1 to DY4	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/MAD 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 within 30 days to establish a numerator for each year.

[159] Centennial Care contract, Section 2 – Definitions, Acronyms and Abbreviations, page 13.

Measure	Measure Name	Definition	Evaluation Methodology	
		"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…"[160][161] HSD/MAD 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 resolved within 30 days of receipt by the MCO.		

[160] Contractors may request an extension from HSD/MAD in accordance with 42 CFR § 438.408(c).
[161] Centennial Care Contract, Section 4.16.2 – Grievances, page 137.

Measure	Measure Name	Definition	Evaluation Methodology	
90 91 92	Percentage of appeals upheld, partially overturned, and overturned	In conformance with federal regulations, HSD/MAD 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 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;*	DY1 to DY4	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/MAD 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	
		• *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)*[162]*.* *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."* [163] Appeals may be upheld (affirming the original determination), partially overturned, or overturned in full. HSD/MAD requires MCOs to track and report 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.		

[162] Section relates to transfers and discharges from long term care facilities.
[163] Centennial Care Contract, Section 4.16.3 –Appeals, pages 147 – 148.

Measure	Measure Name	Definition	Evaluation Methodology	
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/MAD requires that the participating MCOs operate a toll-free Member Services Call Center. HSD/MAD 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."* 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/MAD requires contracting MCOs to report call center performance as a component of their annual HEDIS submissions.	Baseline to DY1	HSD/MAD 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/MAD 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. Note that the NCQA retired this measure after measurement year 2015.

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 satisfied are you with the help you received to coordinate your care in the last 6 months?" is a supplemental CAHPS measure that rates member satisfaction with care coordination activities and services. The CAHPS survey asks members to rate their satisfaction with care coordination using five different rating options, namely "Very satisfied," "Satisfied," "Neither dissatisfied nor satisfied," "Dissatisfied," and "Very dissatisfied." 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.	DY2 to DY4	For the DY2 through DY4, HSD/MAD 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. Note that the CAHPS question that served as the basis for this measure was updated after the Interim Report to use the supplemental question "How satisfied are you with the help you received to coordinate your care in the last 6 months?" as it better aligned with the measure definition. This question was fully rolled out across all MCOs and populations in the DY2 CAHPS report.

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/MAD 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 DY4	For the DY1 through DY4, HSD/MAD 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/MAD 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 DY4	For the DY1 through DY4, HSD/MAD 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/MAD 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 DY4	For the DY1 through DY4, HSD/MAD 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/MAD 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 DY4	For the DY1 through DY4, HSD/MAD 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/MAD 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 DY4	For the DY1 through DY4, HSD/MAD 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/MAD 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: "A clean claim passes all exceptions, does not require an external review, includes complete documentation and pays timely. 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/MAD 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 a time period of no greater than thirty (30) calendar days of receipt;	SFY 2013	For the baseline calculation, HSD/MAD 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, DY3, and DY4	For the DY1, DY3, and DY4 rates, HSD/MAD furnished Deloitte with standardized claims timeliness reports submitted by the four MCOs. The reports covered the 12 months of the applicable calendar year 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 within each respective year 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 reports. Data for the 15/30 day standard was

Measure	Measure Name	Definition	Evaluation Methodology	
		"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." [164] The measure examines claims that have been adjudicated (i.e., paid in full), paid in part and denied in part, or denied in full.		reported only in 2014 and will serve as a baseline for longitudinal analysis.
			DY2	For DY2 HSD/MAD 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.
101	Percentage of claims denied	HSD/MAD requires MCOs to track and report the percentage of denied claims. 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: *"A clean claim passes all exceptions, does not require an external review,*	SFY 2013	For the Baseline calculation, HSD/MAD 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.

[164] Centennial Care contract, Section 4.19 – Claims Management, page 168.

Measure	Measure Name	Definition	Evaluation Methodology	
		includes complete documentation and pays timely. 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."[165] The measure examines clean claims that have been adjudicated and denied.		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, DY3, and DY4	For the DY1, DY3, and DY4 rates, HSD/MAD furnished Deloitte with standardized claims timeliness reports submitted by the four MCOs. The reports covered the 12 months of the applicable calendar year 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 each respective year to establish a denominator. Deloitte then combined the denial counts to establish a numerator.

[165] Centennial Care contract, Section 2 – Definitions, Acronyms and Abbreviations, page 9.

Measure	Measure Name	Definition	Evaluation Methodology	
			DY2	For DY2 HSD/MAD 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/MAD 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/MAD requires separate auditing and reporting of results for ten claim types: • Inpatient hospital	DY1, DY3, and DY4	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/MAD furnished Deloitte with quarterly audit reports submitted by the four MCOs. The reports covered the 12 months of CY2014[166]. 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.

[166] 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/MAD 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/MAD 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."* [167][168] HSD/MAD 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…"*[169][170] HSD/MAD 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 provider grievance activity as a distinct category. Failure to resolve provider grievances timely could	DY1 to DY4	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/MAD 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.

[167] Centennial Care contract, Section 2 – Definitions, Acronyms and Abbreviations, page 13.
[168] Actions refer to service reductions or denials and are addressed through the appeals, rather than grievance, process.
[169] Centennial Care contract, Section 4.16 – Grievances and Appeals, page 146.
[170] Contractors may request an extension from HSD/MAD in accordance with 42CFR Section 438.408(c).

Measure	Measure Name	Definition	Evaluation Methodology	
		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/MAD 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 DY4	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/MAD 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)*[171]*.* *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."*[172] HSD/MAD 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*		

[171] Section relates to transfers and discharges from long term care facilities.
[172] 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."[173] *Expedited appeals – "The contractor shall resolve the expedited appeal in accordance with 42 CFR Section 438.408(b)(3) and (d)(2)."*[174] 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/MAD 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 these appeals timely could contribute to dissatisfaction with the program and		

[173] Centennial Care contract, Section 4.16 – Grievances and Appeals, page 148.
[174] Centennial Care contract, Section 4.16 – Grievances and Appeals, page 149.

Measure	Measure Name	Definition	Evaluation Methodology	
		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. 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 methodology for Medicaid providers in accordance with federal regulations.	2011 to 2017	HSD/MAD 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/MAD in DY1 through DY4.

Measure	Measure Name	Definition	Evaluation Methodology	
		HSD/MAD 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."*[175] HSD/MAD 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/MAD or other entities."*[176] 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 provider types include hospitals and professionals (physicians, dentists,		

[175] Centennial Care contract, Section 2 – Definitions, Acronyms and Abbreviations, pp 11-12.
[176] Centennial Care contract, Section 4.20 – Information Systems, page 176.

Measure	Measure Name	Definition	Evaluation Methodology	
		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/MAD 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 EHR and qualified for an initial incentive payment. In 2012, an additional 5 hospitals and 690 professionals made this attestation. At		

Measure	Measure Name	Definition	Evaluation Methodology	
		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/MAD 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: inadequate pre/post claim editing and invalid pricing/reimbursement logic. HSD/MAD requires separate auditing and reporting of results for ten claim types: • Inpatient hospital	DY1, DY3, and DY4	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/MAD 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[177]. The measure examines percentage of provider claims paid correctly (no overpayment or underpayment) out of the total audited claims.	DY2	For DY2 HSD/MAD 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.

[177] 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 DY4	HSD/MAD 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 summarized by state's actuary and provided via email from HSD	2013	N/A
5	Number and percentage who are receiving home- and community-based services (HCBS)	Ad hoc data summarized by state's actuary and provided via email from HSD	2013	N/A
6	Number and percentage of people with annual dental visit	MCO HEDIS reports	2013	The NCQA State of Health Quality 2018 Report (for CY 2017)
7	Enrollment in Centennial Care as a percentage of state population	State's actuary 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, Family 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 NCQA State of Health Quality 2018 Report (for CY 2017)
12	Number/ratio of members to participating providers	MCO reports (HSD/MAD 3)	2014	N/A
13	Percentage of primary care provider with open panels	MCO reports (HSD/MAD 3)	2014	N/A
14	Number and percentage of substance use disorder participants with follow-up 7 and	MCO reports (HSD/MAD 5)	2014	N/A

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
	30 days after leaving Residential Treatment Center (RTC)			
15	Number and percentage of Behavioral Health (BH) participants with follow-up after hospitalization of mental illness	MCO HEDIS reports	2014	The NCQA State of Health Quality 2018 Report (for CY 2017)
16	Childhood Immunization Status	MCO HEDIS reports	2013	The NCQA State of Health Quality 2018 Report (for CY 2017)
17	Immunization for Adolescents	MCO HEDIS reports	2013	The NCQA State of Health Quality 2018 Report (for CY 2017)
18	Well-Child Visits in First Months of Life	MCO HEDIS reports	2013	The NCQA State of Health Quality 2018 Report (for CY 2017)
19	Well-Child Visits in Third, Fourth, Fifth and Sixth Years of Life	MCO HEDIS reports	2013	The NCQA State of Health Quality 2018 Report (for CY 2017)
20	Adolescent Well Care Visits	MCO HEDIS reports	2013	The NCQA State of Health Quality 2018 Report (for CY 2017)
21	Prenatal and Postpartum Care	MCO HEDIS reports	2013	The NCQA State of Health Quality 2018 Report (for CY 2017)
22	Frequency of Ongoing Prenatal Care	MCO HEDIS reports	2013	The NCQA State of Health Quality 2018 Report (for CY 2017)
23	Breast Cancer Screening for Women	MCO HEDIS reports	2013	The NCQA State of Health Quality 2018 Report (for CY 2017)
24	Cervical Cancer Screening for Women	MCO HEDIS reports	2013	N/A
25	Flu Vaccinations for Adults	Flu Vaccination MMIS reports	2013	N/A

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
26	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment	MCO HEDIS reports	2014	The NCQA State of Health Quality 2018 Report (for CY 2017)
27	Geographic Access Measures	MCO reports (HSD/MAD 55)	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	Ad hoc MCO report	2016	N/A
31	Number and percentage of participants in care coordination Level 3 that had comprehensive needs assessments scheduled and completed within contract timeframes	Ad hoc MCO report	2016	N/A
35	Number and percentage of participants in Nursing Facility (NF) transitioning to community (HCBS)	MCO reports (HSD/MAD 7)	2014	N/A
36	Number and percentage of participants who refuse care coordination	Ad hoc MCO report	2016	N/A
37	EPSDT screening ratio	CMS 416 Report	2013	Federal Fiscal Year (FFY) 2015 National CMS-416 Annual EPSDT Participation Report
38	Annual monitoring for patients on persistent medications	MCO HEDIS reports	2013	The NCQA State of Health Quality 2018 Report (for CY 2017)
39	Medication management for people with asthma	MCO HEDIS reports	2013	The NCQA State of Health Quality 2018 Report (for CY 2017)
40	Asthma medication ratio	MCO HEDIS reports	2013	The NCQA State of Health Quality 2018 Report (for CY 2017)
41	Adult BMI assessment and weight assessment for children/adolescents	MCO HEDIS reports	2013	The NCQA State of Health Quality 2018 Report (for CY 2017)

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
42	Comprehensive diabetes care	MCO HEDIS reports	2013	The NCQA State of Health Quality 2018 Report (for CY 2017)
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/MAD 40)	2014	N/A
48	Medical assistance with smoking and tobacco use cessation	MCO CAHPS reports	2013	The NCQA State of Health Quality 2018 Report (for CY 2017)
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 NCQA State of Health Quality 2018 Report (for CY 2017)
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/MAD 8)	2014	N/A
53	Fall risk intervention	HEDIS rates calculated by the State's actuary	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	LTSS-PCP Visits MMIS reports	2013	N/A

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
	received a PCP visit in the same year			
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 outpatient ambulatory visit in the same year	BH Clients with Outpatient Ambulatory Visits MMIS reports	2013	N/A
63	Diabetes screening for members with schizophrenia or bipolar disorder who are using antipsychotic medications	MCO HEDIS reports	2013	The NCQA State of Health Quality 2018 Report (for CY 2017)
64	Diabetes monitoring for members with diabetes and schizophrenia	MCO HEDIS reports	2013	The NCQA State of Health Quality 2018 Report (for CY 2017)
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

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
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 NCQA State of Health Quality 2018 Report (for CY 2017)
81	Diabetes - annual recommended tests (A1C, LDL, eye exam, nephropathy exam)	MCO HEDIS reports; Finity member rewards data	2013/2014	The NCQA State of Health Quality 2018 Report (for CY 2017)
82	Prenatal program	MCO HEDIS reports; Finity member rewards data	2013/2014	The NCQA State of Health Quality 2018 Report (for CY 2017)
83	Treatment adherence - schizophrenia	MCO HEDIS reports; Finity member rewards data	2013/2014	The NCQA State of Health Quality 2018 Report (for CY 2017)
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 NCQA State of Health Quality 2018 Report (for CY 2017)
87	Annual dental visit - child	MCO HEDIS reports; Finity member rewards data	2013/2014	The NCQA State of Health Quality 2018 Report (for CY 2017)

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
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/MAD 37)	2014	N/A
89	Percentage of grievances resolved within 30 days	MCO reports (HSD/MAD 37)	2014	N/A
90	Percentage of appeals by adjudication (upheld)	MCO reports (HSD/MAD 37)	2014	N/A
91	Percentage of appeals by adjudication (partially overturned)	MCO reports (HSD/MAD 37)	2014	N/A
92	Percentage of appeals by adjudication (overturned in full)	MCO reports (HSD/MAD 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 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/MAD 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/MAD 47); ad hoc MCO claims payment and activity reports	SFY 2013	N/A

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
102	Dollar accuracy rate	MCO reports (HSD/MAD 46); ad hoc MCO claims payment and activity reports	2014	N/A
103	Percentage of grievances resolved on time	MCO reports (HSD/MAD 37)	2014	N/A
104	Percentage of provider appeals resolved on time	MCO reports (HSD/MAD 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/MAD 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/MAD 48)	2014	N/A
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

Centennial Care Evaluation

Access to Preventive/Ambulatory Health Services among Centennial Care Enrollees in Aggregate and in Subgroups (Measure 1)

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4
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)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/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%	76.5%	1.0%	76.1%	-0.5%	-10.0%
Access to preventive/ambulatory health services (45-64 Yrs)	87.3%	85.8%	-1.7%	81.2%	-5.4%	83.0%	2.3%	82.5%	-0.6%	-5.4%
Access to preventive/ambulatory health services (65+ Yrs)	90.0%	88.4%	-1.8%	87.4%	-1.1%	89.6%	2.5%	89.5%	-0.2%	-0.6%
Access to preventive/ambulatory health services (Total)	85.3%	81.9%	-3.9%	77.7%	-5.1%	78.8%	1.4%	78.5%	-0.4%	-7.9%
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%	72.0%	-2.3%	73.4%	1.9%	-10.7%
Access to preventive/ambulatory health services (45-64 Yrs)	86.4%	84.8%	-1.9%	81.9%	-3.4%	80.3%	-2.0%	81.2%	1.2%	-5.9%
Access to preventive/ambulatory health services (65+ Yrs)	91.4%	86.8%	-5.0%	39.8%	-54.1%	41.0%	2.9%	53.5%	30.6%	-41.4%
Access to preventive/ambulatory health services (Total)	83.5%	79.5%	-4.8%	76.1%	-4.3%	74.4%	-2.3%	75.8%	2.0%	-9.1%
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%	68.4%	-5.5%	70.4%	3.0%	-13.1%
Access to preventive/ambulatory health services (45-64 Yrs)	86.1%	82.2%	-4.5%	81.6%	-0.7%	79.1%	-3.0%	79.7%	0.7%	-7.5%
Access to preventive/ambulatory health services (65+ Yrs)	NR	85.9%	N/A	89.6%	4.4%	89.3%	-0.3%	89.6%	0.3%	N/A
Access to preventive/ambulatory health services (Total)	82.5%	76.6%	-7.1%	76.4%	-0.3%	73.1%	-4.3%	74.7%	2.1%	-9.5%
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%	68.4%	-9.2%	69.0%	0.8%	-28.3%
Access to preventive/ambulatory health services (45-64 Yrs)	99.1%	90.8%	-8.3%	88.0%	-3.1%	82.9%	-5.8%	81.9%	-1.2%	-17.3%
Access to preventive/ambulatory health services (65+ Yrs)	97.2%	96.3%	-0.9%	96.9%	0.6%	98.6%	1.8%	96.9%	-1.8%	-0.3%
Access to preventive/ambulatory health services (Total)	98.2%	87.2%	-11.2%	83.5%	-4.3%	78.0%	-6.5%	76.2%	-2.4%	-22.4%
Total										
Access to preventive/ambulatory health services (20-44 Yrs)	83.9%	77.3%	-7.8%	74.2%	-4.0%	72.1%	-2.9%	73.0%	1.2%	-13.0%
Access to preventive/ambulatory health services (45-64 Yrs)	89.0%	86.1%	-3.3%	83.0%	-3.6%	81.2%	-2.2%	81.3%	0.1%	-8.7%
Access to preventive/ambulatory health services (65+ Yrs)	93.8%	91.9%	-2.0%	91.4%	-0.6%	91.3%	-0.1%	90.3%	-1.1%	-3.8%
Access to preventive/ambulatory health services (Total)	85.5%	81.4%	-4.8%	78.1%	-4.1%	76.0%	-2.6%	76.4%	0.5%	-10.6%

Mental Health Services Utilization (Measure 2)

	DY1	DY2		DY3		DY4		DY1 to DY4
Mental health services utilization	**Rate, p_1**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_1-1)**
Presbyterian Health Plan								
Mental Health Utilization (0-12 Yrs, Male)	12.2%	11.6%	-4.4%	11.5%	-1.2%	11.8%	3.2%	-2.5%
Mental Health Utilization (0-12 Yrs, Female)	8.9%	8.7%	-2.1%	8.7%	-0.6%	9.1%	5.1%	2.3%
Mental Health Utilization (0-12 Yrs, Total)	10.6%	10.2%	-3.4%	10.1%	-1.0%	10.5%	4.0%	-0.5%
Mental Health Utilization (13-17 Yrs, Male)	18.0%	17.1%	-5.0%	16.5%	-3.9%	16.8%	2.2%	-6.7%
Mental Health Utilization (13-17 Yrs, Female)	19.4%	19.1%	-1.4%	18.8%	-1.5%	20.4%	8.4%	5.2%
Mental Health Utilization (13-17 Yrs, Total)	18.7%	18.1%	-3.2%	17.6%	-2.6%	18.6%	5.4%	-0.6%
Mental Health Utilization (18-64 Yrs, Male)	16.0%	14.4%	-9.9%	14.2%	-1.2%	13.8%	-2.7%	-13.4%
Mental Health Utilization (18-64 Yrs, Female)	16.5%	16.9%	2.0%	17.3%	2.8%	17.9%	3.1%	8.1%
Mental Health Utilization (18-64 Yrs, Total)	16.3%	15.9%	-2.5%	16.1%	1.0%	16.2%	0.8%	-0.8%
Mental Health Utilization (65+ Yrs, Male)	7.9%	8.6%	8.9%	7.3%	-15.9%	7.4%	2.5%	-6.1%
Mental Health Utilization (65+ Yrs, Female)	10.2%	12.0%	17.7%	11.8%	-2.0%	11.3%	-4.3%	10.4%
Mental Health Utilization (65+ Yrs, Total)	9.4%	10.8%	15.0%	10.1%	-6.4%	9.9%	-2.6%	5.0%
Mental Health Utilization (Total, Male)	14.3%	13.5%	-5.4%	13.3%	-1.3%	13.4%	0.7%	-6.0%
Mental Health Utilization (Total, Female)	13.8%	14.1%	2.3%	14.4%	2.5%	15.2%	4.9%	10.0%
Mental Health Utilization (Grand Total)	14.0%	13.8%	-1.2%	13.9%	0.8%	14.4%	3.0%	2.5%
Molina Healthcare of New Mexico, Inc.								
Mental Health Utilization (0-12 Yrs, Male)	9.9%	9.7%	-2.9%	9.6%	-0.7%	10.5%	9.4%	5.6%
Mental Health Utilization (0-12 Yrs, Female)	7.3%	7.4%	1.6%	7.4%	0.2%	7.9%	6.5%	8.3%
Mental Health Utilization (0-12 Yrs, Total)	8.7%	8.6%	-1.0%	8.5%	-0.3%	9.2%	8.2%	6.8%
Mental Health Utilization (13-17 Yrs, Male)	16.5%	16.5%	0.4%	15.9%	-3.5%	16.0%	0.2%	-2.9%
Mental Health Utilization (13-17 Yrs, Female)	18.1%	17.9%	-1.3%	18.3%	2.4%	19.9%	8.3%	9.5%
Mental Health Utilization (13-17 Yrs, Total)	17.3%	17.2%	-0.5%	17.1%	-0.5%	17.9%	4.5%	3.5%
Mental Health Utilization (18-64 Yrs, Male)	14.6%	14.2%	-3.0%	14.5%	2.4%	14.9%	2.8%	2.0%
Mental Health Utilization (18-64 Yrs, Female)	15.1%	16.2%	7.4%	17.1%	5.6%	17.7%	3.6%	17.5%
Mental Health Utilization (18-64 Yrs, Total)	14.9%	15.4%	3.1%	16.0%	4.2%	16.5%	3.2%	10.9%
Mental Health Utilization (65+ Yrs, Male)	8.8%	8.9%	0.9%	6.6%	-25.5%	4.8%	-27.9%	-45.8%
Mental Health Utilization (65+ Yrs, Female)	11.3%	10.1%	-10.5%	8.5%	-16.0%	12.2%	42.8%	7.4%
Mental Health Utilization (65+ Yrs, Total)	10.4%	9.6%	-7.1%	7.7%	-20.1%	9.1%	18.1%	-12.4%
Mental Health Utilization (Total, Male)	12.5%	12.5%	-0.6%	12.6%	0.9%	13.2%	4.8%	5.1%
Mental Health Utilization (Total, Female)	12.4%	13.1%	5.7%	13.7%	4.7%	14.5%	5.4%	16.7%
Mental Health Utilization (Grand Total)	12.5%	12.8%	2.8%	13.2%	3.0%	13.9%	5.1%	11.3%

Mental Health Services Utilization (Continued)

	DY1	DY2		DY3		DY4		DY1 to DY4
Mental health services utilization	**Rate, p_1**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_1-1)**
Blue Cross and Blue Shield of New Mexico								
Mental Health Utilization (0-12 Yrs, Male)	10.9%	8.9%	-18.3%	8.9%	0.1%	9.5%	6.4%	-12.9%
Mental Health Utilization (0-12 Yrs, Female)	7.8%	6.6%	-15.7%	6.7%	2.2%	7.3%	8.8%	-6.3%
Mental Health Utilization (0-12 Yrs, Total)	9.4%	7.8%	-17.2%	7.8%	1.0%	8.4%	7.4%	-10.2%
Mental Health Utilization (13-17 Yrs, Male)	18.2%	15.5%	-15.2%	15.3%	-1.1%	17.3%	13.5%	-4.8%
Mental Health Utilization (13-17 Yrs, Female)	20.9%	17.6%	-16.0%	17.6%	0.2%	20.5%	16.4%	-2.0%
Mental Health Utilization (13-17 Yrs, Total)	19.5%	16.5%	-15.5%	16.4%	-0.5%	18.9%	15.1%	-3.2%
Mental Health Utilization (18-64 Yrs, Male)	18.1%	15.4%	-14.9%	15.1%	-1.9%	15.4%	2.1%	-14.8%
Mental Health Utilization (18-64 Yrs, Female)	19.3%	17.5%	-9.2%	17.9%	2.2%	18.6%	4.1%	-3.4%
Mental Health Utilization (18-64 Yrs, Total)	18.7%	16.5%	-11.9%	16.6%	0.3%	17.1%	3.2%	-8.7%
Mental Health Utilization (65+ Yrs, Male)	15.3%	12.8%	-16.2%	11.5%	-10.4%	13.2%	15.1%	-13.6%
Mental Health Utilization (65+ Yrs, Female)	18.4%	15.4%	-16.3%	14.2%	-7.8%	15.6%	9.7%	-15.4%
Mental Health Utilization (65+ Yrs, Total)	17.2%	14.4%	-16.2%	13.2%	-8.7%	14.7%	11.4%	-14.8%
Mental Health Utilization (Total, Male)	15.6%	13.3%	-14.6%	13.1%	-1.2%	13.7%	4.2%	-12.1%
Mental Health Utilization (Total, Female)	16.0%	14.4%	-10.1%	14.7%	1.8%	15.5%	5.9%	-3.1%
Mental Health Utilization (Grand Total)	15.8%	13.9%	-12.3%	13.9%	0.4%	14.6%	5.2%	-7.4%
United Healthcare of New Mexico, Inc.								
Mental Health Utilization (0-12 Yrs, Male)	9.6%	8.2%	-14.1%	8.0%	-3.2%	7.9%	-1.3%	-17.9%
Mental Health Utilization (0-12 Yrs, Female)	6.9%	5.6%	-17.8%	5.6%	-0.4%	5.6%	-0.6%	-18.7%
Mental Health Utilization (0-12 Yrs, Total)	8.3%	7.0%	-15.4%	6.8%	-2.1%	6.8%	-1.2%	-18.1%
Mental Health Utilization (13-17 Yrs, Male)	17.6%	15.6%	-11.7%	16.8%	7.9%	15.6%	-7.3%	-11.8%
Mental Health Utilization (13-17 Yrs, Female)	18.4%	17.0%	-7.5%	18.2%	7.2%	18.7%	2.8%	1.9%
Mental Health Utilization (13-17 Yrs, Total)	18.0%	16.3%	-9.5%	17.5%	7.5%	17.1%	-2.3%	-4.9%
Mental Health Utilization (18-64 Yrs, Male)	17.5%	16.8%	-3.8%	17.2%	2.3%	15.8%	-8.0%	-9.5%
Mental Health Utilization (18-64 Yrs, Female)	19.3%	19.1%	-1.0%	21.2%	10.8%	19.3%	-9.1%	-0.2%
Mental Health Utilization (18-64 Yrs, Total)	18.5%	18.0%	-2.5%	19.2%	6.8%	17.6%	-8.6%	-4.8%
Mental Health Utilization (65+ Yrs, Male)	10.3%	9.4%	-9.1%	8.9%	-4.7%	7.0%	-21.8%	-32.3%
Mental Health Utilization (65+ Yrs, Female)	11.6%	11.0%	-5.0%	12.6%	14.2%	11.2%	-11.0%	-3.4%
Mental Health Utilization (65+ Yrs, Total)	11.2%	10.5%	-6.2%	11.4%	8.8%	9.8%	-14.5%	-12.8%
Mental Health Utilization (Total, Male)	15.6%	14.7%	-5.8%	14.8%	0.8%	13.8%	-7.2%	-11.9%
Mental Health Utilization (Total, Female)	16.4%	15.9%	-3.2%	17.3%	8.9%	16.0%	-7.6%	-2.6%
Mental Health Utilization (Grand Total)	16.0%	15.3%	-4.5%	16.1%	5.1%	14.9%	-7.6%	-7.2%

Mental Health Services Utilization (continued)

	DY1	DY2		DY3		DY4		DY1 to DY4
Mental health services utilization	**Rate, p_1**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_1-1)**
Total								
Mental Health Utilization (0-12 Yrs, Male)	11.0%	10.2%	-6.9%	10.1%	-1.3%	10.6%	5.2%	-3.3%
Mental Health Utilization (0-12 Yrs, Female)	8.0%	7.7%	-4.1%	7.7%	-0.3%	8.1%	5.3%	0.7%
Mental Health Utilization (0-12 Yrs, Total)	9.5%	9.0%	-5.7%	8.9%	-0.9%	9.4%	5.2%	-1.6%
Mental Health Utilization (13-17 Yrs, Male)	17.4%	16.6%	-4.8%	16.1%	-2.8%	16.5%	2.4%	-5.2%
Mental Health Utilization (13-17 Yrs, Female)	19.0%	18.3%	-3.6%	18.4%	0.5%	20.1%	9.1%	5.8%
Mental Health Utilization (13-17 Yrs, Total)	18.2%	17.5%	-4.1%	17.3%	-1.1%	18.3%	6.0%	0.5%
Mental Health Utilization (18-64 Yrs, Male)	16.3%	15.1%	-7.5%	15.1%	0.0%	14.9%	-1.1%	-8.5%
Mental Health Utilization (18-64 Yrs, Female)	16.9%	17.2%	1.4%	17.9%	4.7%	18.2%	1.4%	7.6%
Mental Health Utilization (18-64 Yrs, Total)	16.7%	16.3%	-2.4%	16.7%	2.6%	16.7%	0.3%	0.5%
Mental Health Utilization (65+ Yrs, Male)	10.4%	10.0%	-3.6%	9.1%	-9.7%	9.2%	1.7%	-11.5%
Mental Health Utilization (65+ Yrs, Female)	12.3%	12.1%	-1.5%	12.6%	4.2%	12.7%	0.6%	3.3%
Mental Health Utilization (65+ Yrs, Total)	11.7%	11.4%	-2.1%	11.4%	-0.2%	11.4%	0.4%	-1.9%
Mental Health Utilization (Total, Male)	14.0%	13.3%	-5.2%	13.2%	-0.3%	13.4%	1.6%	-3.9%
Mental Health Utilization (Total, Female)	13.9%	14.1%	1.1%	14.6%	3.9%	15.1%	3.5%	8.7%
Mental Health Utilization (Grand Total)	13.9%	13.7%	-1.8%	14.0%	2.0%	14.3%	2.6%	2.8%

Number and percentage of people with an annual dental visit (Measure 6, 85, & 86)[178]

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4
Annual dental visit	**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)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**
Presbyterian Health Plan										
Annual Dental Visit (2-3 Yrs)	55.6%	54.4%	-2.3%	52.9%	-2.6%	57.0%	7.7%	58.9%	3.3%	5.8%
Annual Dental Visit (4-6 Yrs)	75.0%	73.2%	-2.5%	71.7%	-2.1%	74.4%	3.8%	76.0%	2.2%	1.3%
Annual Dental Visit (7-10 Yrs)	79.1%	76.7%	-3.0%	75.0%	-2.3%	77.1%	2.9%	79.4%	2.9%	0.3%
Annual Dental Visit (11-14 Yrs)	74.1%	72.6%	-2.0%	70.6%	-2.8%	74.2%	5.1%	75.3%	1.5%	1.6%
Annual Dental Visit (15-18 Yrs)	64.3%	61.9%	-3.7%	61.5%	-0.7%	63.9%	4.0%	65.4%	2.2%	1.7%
Annual Dental Visit (19-21 Yrs)	44.2%	39.3%	-11.1%	41.2%	4.8%	42.9%	4.2%	45.8%	6.5%	3.4%
Annual Dental Visit (Total)	71.0%	68.1%	-4.1%	66.4%	-2.5%	69.0%	3.9%	70.9%	2.7%	-0.3%
Molina Healthcare of New Mexico, Inc.										
Annual Dental Visit (2-3 Yrs)	55.6%	51.1%	-8.1%	57.8%	13.2%	58.2%	0.6%	61.9%	6.4%	11.4%
Annual Dental Visit (4-6 Yrs)	74.3%	67.8%	-8.6%	74.8%	10.2%	75.0%	0.4%	77.6%	3.4%	4.5%
Annual Dental Visit (7-10 Yrs)	78.9%	71.0%	-10.0%	78.3%	10.2%	78.4%	0.2%	80.5%	2.7%	2.1%
Annual Dental Visit (11-14 Yrs)	74.2%	66.2%	-10.9%	74.7%	12.9%	75.6%	1.2%	78.0%	3.2%	5.0%
Annual Dental Visit (15-18 Yrs)	64.0%	57.1%	-10.9%	65.1%	14.1%	65.9%	1.2%	69.4%	5.3%	8.4%
Annual Dental Visit (19-21 Yrs)	45.9%	35.5%	-22.8%	43.6%	22.9%	43.8%	0.6%	51.2%	16.7%	11.4%
Annual Dental Visit (Total)	70.9%	62.7%	-11.5%	70.1%	11.7%	70.4%	0.5%	73.6%	4.6%	3.9%
Blue Cross and Blue Shield of New Mexico										
Annual Dental Visit (2-3 Yrs)	56.5%	47.8%	-15.4%	48.8%	2.0%	51.1%	4.7%	55.6%	8.7%	-1.7%
Annual Dental Visit (4-6 Yrs)	73.3%	63.3%	-13.7%	65.2%	3.1%	67.2%	3.0%	70.5%	4.9%	-3.9%
Annual Dental Visit (7-10 Yrs)	75.5%	66.9%	-11.3%	68.1%	1.7%	70.7%	3.9%	72.4%	2.4%	-4.1%
Annual Dental Visit (11-14 Yrs)	68.1%	61.4%	-9.9%	63.5%	3.4%	66.8%	5.3%	68.0%	1.8%	-0.1%
Annual Dental Visit (15-18 Yrs)	59.1%	51.4%	-13.0%	55.2%	7.3%	56.4%	2.2%	59.0%	4.5%	-0.3%
Annual Dental Visit (19-21 Yrs)	41.0%	29.6%	-27.8%	37.1%	25.2%	37.8%	1.9%	39.2%	3.8%	-4.4%
Annual Dental Visit (Total)	66.8%	57.5%	-14.0%	59.6%	3.8%	61.8%	3.6%	64.4%	4.2%	-3.6%
United Healthcare of New Mexico, Inc.										
Annual Dental Visit (2-3 Yrs)	NR	36.4%	N/A	41.8%	14.6%	46.1%	10.3%	54.2%	17.7%	N/A
Annual Dental Visit (4-6 Yrs)	NR	51.3%	N/A	58.4%	13.9%	59.5%	1.8%	66.8%	12.3%	N/A
Annual Dental Visit (7-10 Yrs)	NR	54.8%	N/A	59.2%	8.0%	63.2%	6.8%	69.7%	10.3%	N/A
Annual Dental Visit (11-14 Yrs)	NR	48.8%	N/A	54.6%	12.0%	59.6%	9.1%	65.8%	10.5%	N/A
Annual Dental Visit (15-18 Yrs)	NR	39.9%	N/A	42.3%	6.2%	48.0%	13.4%	56.0%	16.7%	N/A
Annual Dental Visit (19-21 Yrs)	NR	25.9%	N/A	28.6%	10.4%	32.3%	13.2%	38.8%	20.0%	N/A
Annual Dental Visit (Total)	51.5%	41.5%	-19.4%	49.9%	20.1%	53.9%	8.1%	61.0%	13.2%	18.5%
Total										
Annual Dental Visit (2-3 Yrs)	55.7%	51.6%	-7.5%	53.5%	3.8%	55.4%	3.5%	58.7%	6.0%	5.4%
Annual Dental Visit (4-6 Yrs)	74.6%	69.3%	-7.1%	71.1%	2.7%	72.5%	1.9%	75.1%	3.5%	0.6%
Annual Dental Visit (7-10 Yrs)	78.7%	72.9%	-7.4%	74.6%	2.3%	76.0%	1.9%	78.2%	2.9%	-0.7%
Annual Dental Visit (11-14 Yrs)	73.6%	68.4%	-7.1%	70.4%	3.0%	73.0%	3.6%	74.8%	2.5%	1.6%
Annual Dental Visit (15-18 Yrs)	63.8%	58.5%	-8.3%	61.0%	4.4%	62.8%	2.9%	65.4%	4.1%	2.6%
Annual Dental Visit (19-21 Yrs)	44.4%	34.9%	-21.5%	40.4%	15.9%	41.8%	3.4%	46.2%	10.6%	4.0%
Annual Dental Visit (Total)	70.6%	64.0%	-9.3%	66.0%	3.1%	67.6%	2.4%	70.3%	3.9%	-0.4%

[178] UHC baseline numerator and denominator were included in the calculation of aggregate rates; "NR" is shown since the denominator was less than 30.

Enrollment in Centennial Care as a Percentage of State Population (Measure 7)

	DY1			DY2		DY3		DY4	
Enrollment in Centennial Care as a Percentage of State Population	**Rate, p_1**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**DY1 to DY4 Change (p_4/p_1-1)**
Total								
Enrollment in Centennial Care as a Percentage of State Population	27.3%	30.9%	13.2%	32.8%	6.0%	33.1%	1.0%	21.3%

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		DY3		DY4	
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**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**DY1 to DY4 Change (p_4/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)	1.0%	1.1%	7.8%	1.2%	8.4%	1.0%	-14.4%	0.1%

Number and percentage of Unduplicated Participants with at Least One PCP Visit (Measure 11)

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4
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)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**
Total										
Number and percentage of unduplicated participants with at least one PCP visit, in aggregate and among subgroups	65.5%	59.3%	-9.5%	59.3%	0.0%	58.0%	-2.2%	49.3%	-15.0%	-24.8%

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

	DY1		DY2		DY3		DY4		DY1 to DY4
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)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/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%	29.3%	8.4%	23.9%	-18.4%	-44.3%
Percent of Members Seen for Follow-Up within 30 Days of Discharge from RTC	64.7%	N/A	47.7%	-26.3%	49.4%	3.7%	49.3%	-0.3%	-23.8%
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%	17.5%	-29.5%	17.8%	1.7%	31.0%
Percent of Members Seen for Follow-Up within 30 Days of Discharge from RTC	22.0%	N/A	41.0%	86.3%	38.6%	-5.7%	34.9%	-9.7%	58.6%
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%	14.7%	27.7%	16.7%	13.5%	20.8%
Percent of Members Seen for Follow-Up within 30 Days of Discharge from RTC	30.3%	N/A	28.7%	-5.3%	27.5%	-4.2%	35.7%	29.8%	17.7%
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	71.4%	23.0%	50.0%	-30.0%	N/A
Percent of Members Seen for Follow-Up within 30 Days of Discharge from RTC	NR	N/A	74.2%	N/A	82.1%	10.7%	69.4%	-15.5%	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%	24.1%	-6.1%	21.8%	-9.5%	-17.6%
Percent of Members Seen for Follow-Up within 30 Days of Discharge from RTC	43.2%	N/A	44.0%	1.9%	43.0%	-2.3%	42.3%	-1.6%	-2.0%

Follow-up after Hospitalization of Mental Illness (Measure 15)[179]

	DY1		DY2		DY3		DY4		DY1 to DY4
Number and percentage of BH participants with follow-up after hospitalization of mental illness	**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)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_1-1)**
Presbyterian Health Plan									
Follow-Up After Hospitalization for Mental Illness (30-day)	67.9%	N/A	59.7%	-12.0%	62.1%	4.0%	63.8%	2.6%	-6.1%
Follow-Up After Hospitalization for Mental Illness (7-day)	43.1%	N/A	32.6%	-24.5%	38.4%	17.8%	38.9%	1.3%	-9.9%
Molina Healthcare of New Mexico, Inc.									
Follow-Up After Hospitalization for Mental Illness (30-day)	64.8%	N/A	59.8%	-7.8%	63.8%	6.8%	63.5%	-0.5%	-2.1%
Follow-Up After Hospitalization for Mental Illness (7-day)	41.8%	N/A	34.6%	-17.1%	37.5%	8.2%	39.3%	4.7%	-6.1%
Blue Cross and Blue Shield of New Mexico									
Follow-Up After Hospitalization for Mental Illness (30-day)	58.5%	N/A	55.1%	-5.8%	58.3%	5.7%	58.6%	0.6%	0.2%
Follow-Up After Hospitalization for Mental Illness (7-day)	39.0%	N/A	34.3%	-12.1%	37.2%	8.6%	37.4%	0.5%	-4.1%
United Healthcare of New Mexico, Inc.									
Follow-Up After Hospitalization for Mental Illness (30-day)	71.0%	N/A	73.1%	2.9%	74.6%	2.1%	59.0%	-20.9%	-16.9%
Follow-Up After Hospitalization for Mental Illness (7-day)	55.2%	N/A	55.0%	-0.4%	57.9%	5.4%	35.3%	-39.2%	-36.1%
Total									
Follow-Up After Hospitalization for Mental Illness (30-day)	65.3%	N/A	60.9%	-6.9%	63.8%	4.8%	61.6%	-3.5%	-5.7%
Follow-Up After Hospitalization for Mental Illness (7-day)	43.8%	N/A	37.6%	-14.2%	41.1%	9.5%	38.0%	-7.6%	-13.2%

[179] 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		DY3		DY4		Baseline to DY4
Childhood Immunization Status	**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)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**
Presbyterian Health Plan										
Childhood Immunization Status (DTaP)	77.3%	79.2%	2.4%	75.9%	-4.1%	71.5%	-5.8%	71.0%	-0.7%	-8.1%
Childhood Immunization Status (IPV)	88.0%	88.0%	0.0%	87.3%	-0.8%	82.6%	-5.3%	81.5%	-1.4%	-7.3%
Childhood Immunization Status (MMR)	87.5%	91.2%	4.2%	85.2%	-6.6%	85.6%	0.5%	83.5%	-2.6%	-4.6%
Childhood Immunization Status (HiB)	90.0%	90.3%	0.3%	87.3%	-3.3%	82.6%	-5.3%	83.9%	1.6%	-6.8%
Childhood Immunization Status (Hepatitis B)	79.2%	81.3%	2.6%	83.8%	3.1%	77.1%	-8.0%	79.8%	3.5%	0.8%
Childhood Immunization Status (VZV)	88.0%	90.5%	2.9%	85.0%	-6.1%	84.5%	-0.5%	83.7%	-0.9%	-4.8%
Childhood Immunization Status (Pneumo- coccal Conjugate)	80.6%	78.0%	-3.2%	76.4%	-2.1%	73.1%	-4.2%	71.8%	-1.9%	-10.9%
Childhood Immunization Status (Hepatitis A)	86.1%	87.3%	1.3%	84.5%	-3.2%	82.9%	-1.9%	83.7%	1.0%	-2.8%
Childhood Immunization Status (Rotavirus)	73.1%	75.5%	3.2%	75.9%	0.6%	67.4%	-11.3%	71.5%	6.2%	-2.2%
Childhood Immunization Status (Influenza)	57.2%	53.9%	-5.7%	52.1%	-3.4%	47.0%	-9.8%	50.9%	8.2%	-11.1%
Childhood Immunization Status (Combination 2)	67.4%	69.4%	3.1%	69.7%	0.3%	64.4%	-7.6%	63.7%	-0.9%	-5.4%
Childhood Immunization Status (Combination 3)	66.0%	64.6%	-2.1%	66.4%	2.9%	61.8%	-7.0%	62.0%	0.4%	-6.0%
Childhood Immunization Status (Combination 4)	63.0%	61.8%	-1.8%	65.0%	5.2%	60.4%	-7.1%	61.1%	1.1%	-3.0%
Childhood Immunization Status (Combination 5)	57.6%	56.5%	-2.0%	59.7%	5.7%	55.8%	-6.6%	56.4%	1.2%	-2.1%
Childhood Immunization Status (Combination 6)	44.4%	39.1%	-12.0%	44.0%	12.4%	37.5%	-14.7%	39.9%	6.4%	-10.2%
Childhood Immunization Status (Combination 7)	55.8%	54.4%	-2.5%	58.3%	7.2%	54.6%	-6.3%	56.0%	2.4%	0.3%
Childhood Immunization Status (Combination 8)	43.1%	38.2%	-11.3%	43.5%	13.9%	37.3%	-14.4%	39.7%	6.4%	-7.9%
Childhood Immunization Status (Combination 9)	39.4%	35.2%	-10.6%	39.4%	11.8%	33.8%	-14.1%	36.0%	6.5%	-8.5%
Childhood Immunization Status (Combination 10)	38.7%	34.5%	-10.8%	38.9%	12.8%	33.8%	-13.1%	36.0%	6.5%	-6.8%
Molina Healthcare of New Mexico, Inc.										
Childhood Immunization Status (DTaP)	81.9%	83.0%	1.3%	70.6%	-14.9%	76.4%	8.1%	77.4%	1.3%	-5.5%
Childhood Immunization Status (IPV)	92.5%	93.2%	0.7%	84.8%	-9.0%	88.1%	3.9%	91.2%	3.6%	-1.4%
Childhood Immunization Status (MMR)	92.1%	93.4%	1.4%	87.2%	-6.6%	88.3%	1.3%	89.8%	1.7%	-2.5%
Childhood Immunization Status (HiB)	92.3%	93.2%	1.0%	83.9%	-10.0%	87.2%	3.9%	88.6%	1.6%	-4.0%
Childhood Immunization Status (Hepatitis B)	92.1%	92.9%	1.0%	84.8%	-8.8%	87.6%	3.4%	92.0%	4.9%	-0.1%
Childhood Immunization Status (VZV)	92.3%	92.9%	0.7%	86.3%	-7.1%	88.1%	2.0%	89.3%	1.4%	-3.2%
Childhood Immunization Status (Pneumo- coccal Conjugate)	80.1%	82.6%	3.0%	71.5%	-13.4%	76.4%	6.8%	75.7%	-0.9%	-5.6%
Childhood Immunization Status (Hepatitis A)	87.9%	89.6%	2.0%	83.4%	-6.9%	85.0%	1.9%	87.1%	2.5%	-0.9%
Childhood Immunization Status (Rotavirus)	72.6%	76.4%	5.2%	67.8%	-11.3%	71.3%	5.2%	74.7%	4.8%	2.8%
Childhood Immunization Status (Influenza)	53.6%	54.5%	1.6%	41.9%	-23.1%	44.8%	6.8%	47.9%	7.0%	-10.6%
Childhood Immunization Status (Combination 2)	78.6%	80.8%	2.8%	67.1%	-16.9%	73.1%	8.9%	75.7%	3.6%	-3.7%
Childhood Immunization Status (Combination 3)	73.3%	77.7%	6.0%	64.7%	-16.8%	69.8%	7.8%	71.5%	2.5%	-2.4%
Childhood Immunization Status (Combination 4)	71.1%	75.1%	5.6%	62.0%	-17.4%	68.0%	9.6%	70.3%	3.4%	-1.1%
Childhood Immunization Status (Combination 5)	59.6%	66.4%	11.5%	57.8%	-13.0%	59.6%	3.1%	64.7%	8.6%	8.6%
Childhood Immunization Status (Combination 6)	46.1%	50.3%	9.1%	35.3%	-29.8%	39.1%	10.6%	42.3%	8.4%	-8.2%
Childhood Immunization Status (Combination 7)	57.8%	64.2%	11.1%	55.4%	-13.7%	58.1%	4.8%	63.7%	9.8%	10.2%
Childhood Immunization Status (Combination 8)	45.5%	49.4%	8.7%	34.7%	-29.9%	39.1%	12.7%	42.3%	8.4%	-6.9%
Childhood Immunization Status (Combination 9)	40.4%	45.7%	13.1%	32.7%	-28.5%	35.3%	8.1%	39.2%	10.9%	-3.0%
Childhood Immunization Status (Combination 10)	39.7%	44.8%	12.8%	32.0%	-28.6%	35.3%	10.3%	39.2%	10.9%	-1.4%

Childhood Immunization Status (Continued)

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4
Childhood Immunization Status	**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)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/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%	76.2%	4.9%	78.1%	2.6%	-4.5%
Childhood Immunization Status (IPV)	92.2%	92.7%	0.5%	86.3%	-6.9%	88.3%	2.3%	90.0%	2.0%	-2.4%
Childhood Immunization Status (MMR)	91.8%	90.5%	-1.4%	87.0%	-3.9%	87.2%	0.3%	87.6%	0.5%	-4.6%
Childhood Immunization Status (HiB)	92.0%	92.9%	1.0%	85.0%	-8.6%	87.4%	2.9%	87.8%	0.5%	-4.5%
Childhood Immunization Status (Hepatitis B)	91.4%	92.7%	1.5%	87.2%	-6.0%	88.3%	1.3%	87.6%	-0.8%	-4.1%
Childhood Immunization Status (VZV)	92.7%	90.1%	-2.8%	87.0%	-3.4%	87.4%	0.5%	86.9%	-0.6%	-6.3%
Childhood Immunization Status (Pneumo- coccal Conjugate)	80.0%	80.8%	0.9%	74.0%	-8.5%	75.7%	2.4%	79.6%	5.1%	-0.6%
Childhood Immunization Status (Hepatitis A)	87.1%	88.5%	1.6%	83.9%	-5.2%	87.2%	3.9%	84.4%	-3.2%	-3.1%
Childhood Immunization Status (Rotavirus)	74.1%	74.8%	1.0%	68.7%	-8.3%	75.3%	9.6%	76.4%	1.5%	3.2%
Childhood Immunization Status (Influenza)	52.8%	51.4%	-2.5%	52.8%	2.6%	42.6%	-19.2%	48.4%	13.6%	-8.2%
Childhood Immunization Status (Combination 2)	78.3%	76.8%	-1.9%	70.9%	-7.8%	72.8%	2.8%	73.5%	0.9%	-6.1%
Childhood Immunization Status (Combination 3)	73.8%	74.4%	0.8%	67.8%	-8.9%	70.2%	3.6%	69.6%	-0.9%	-5.8%
Childhood Immunization Status (Combination 4)	71.8%	73.1%	1.7%	65.8%	-10.0%	69.8%	6.0%	68.1%	-2.3%	-5.2%
Childhood Immunization Status (Combination 5)	62.3%	63.4%	1.7%	57.4%	-9.4%	62.0%	8.1%	62.3%	0.4%	0.0%
Childhood Immunization Status (Combination 6)	45.9%	45.7%	-0.4%	45.9%	0.5%	37.3%	-18.8%	40.9%	9.6%	-10.9%
Childhood Immunization Status (Combination 7)	61.4%	62.7%	2.1%	55.6%	-11.3%	61.8%	11.1%	61.3%	-0.8%	-0.2%
Childhood Immunization Status (Combination 8)	45.0%	45.7%	1.5%	44.4%	-2.9%	36.9%	-16.9%	40.4%	9.6%	-10.3%
Childhood Immunization Status (Combination 9)	39.9%	40.4%	1.2%	39.1%	-3.3%	34.4%	-11.9%	37.2%	8.1%	-6.7%
Childhood Immunization Status (Combination 10)	39.2%	40.4%	2.9%	37.7%	-6.6%	34.2%	-9.4%	36.7%	7.4%	-6.4%
United Healthcare of New Mexico, Inc.										
Childhood Immunization Status (DTaP)	NR	65.7%	N/A	51.3%	-21.9%	72.0%	40.3%	71.8%	-0.3%	N/A
Childhood Immunization Status (IPV)	NR	74.3%	N/A	62.5%	-15.8%	84.7%	35.4%	84.4%	-0.3%	N/A
Childhood Immunization Status (MMR)	NR	80.0%	N/A	71.8%	-10.3%	86.6%	20.7%	83.5%	-3.7%	N/A
Childhood Immunization Status (HiB)	NR	75.7%	N/A	64.7%	-14.5%	83.7%	29.3%	85.4%	2.0%	N/A
Childhood Immunization Status (Hepatitis B)	NR	74.3%	N/A	60.8%	-18.1%	83.7%	37.6%	83.7%	0.0%	N/A
Childhood Immunization Status (VZV)	NR	80.0%	N/A	71.3%	-10.9%	86.1%	20.8%	82.5%	-4.2%	N/A
Childhood Immunization Status (Pneumo- coccal Conjugate)	NR	67.1%	N/A	50.1%	-25.4%	75.4%	50.5%	72.3%	-4.2%	N/A
Childhood Immunization Status (Hepatitis A)	NR	75.7%	N/A	72.5%	-4.2%	84.9%	17.1%	81.5%	-4.0%	N/A
Childhood Immunization Status (Rotavirus)	NR	64.3%	N/A	44.3%	-31.1%	70.8%	59.9%	73.2%	3.4%	N/A
Childhood Immunization Status (Influenza)	NR	41.4%	N/A	34.8%	-16.0%	47.2%	35.7%	51.6%	9.3%	N/A
Childhood Immunization Status (Combination 2)	NR	60.0%	N/A	47.0%	-21.7%	66.7%	42.0%	69.3%	4.0%	N/A
Childhood Immunization Status (Combination 3)	NR	58.6%	N/A	43.6%	-25.6%	64.7%	48.6%	65.2%	0.8%	N/A
Childhood Immunization Status (Combination 4)	NR	55.7%	N/A	43.1%	-22.7%	63.0%	46.3%	64.7%	2.7%	N/A
Childhood Immunization Status (Combination 5)	NR	51.4%	N/A	34.3%	-33.3%	58.4%	70.2%	58.6%	0.4%	N/A
Childhood Immunization Status (Combination 6)	NR	31.4%	N/A	26.0%	-17.2%	39.9%	53.3%	43.3%	8.5%	N/A
Childhood Immunization Status (Combination 7)	NR	48.6%	N/A	33.8%	-30.4%	56.7%	67.6%	58.2%	2.6%	N/A
Childhood Immunization Status (Combination 8)	NR	31.4%	N/A	26.0%	-17.2%	39.4%	51.4%	43.3%	9.9%	N/A
Childhood Immunization Status (Combination 9)	NR	25.7%	N/A	22.4%	-12.9%	36.7%	64.1%	39.9%	8.6%	N/A
Childhood Immunization Status (Combination 10)	NR	25.7%	N/A	22.4%	-12.9%	36.3%	62.0%	39.9%	10.1%	N/A

Childhood Immunization Status (Continued)

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4
Childhood Immunization Status	**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)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**
Total										
Childhood Immunization Status (DTaP)	80.4%	80.2%	-0.3%	67.9%	-15.3%	74.1%	9.1%	74.6%	0.6%	-7.2%
Childhood Immunization Status (IPV)	90.9%	90.5%	-0.5%	80.6%	-11.0%	86.0%	6.7%	86.8%	0.9%	-4.6%
Childhood Immunization Status (MMR)	90.5%	91.1%	0.7%	83.0%	-8.9%	87.0%	4.8%	86.1%	-1.0%	-4.9%
Childhood Immunization Status (HiB)	91.5%	91.3%	-0.1%	80.5%	-11.9%	85.3%	6.0%	86.4%	1.3%	-5.5%
Childhood Immunization Status (Hepatitis B)	87.6%	88.4%	0.8%	79.5%	-10.0%	84.3%	6.0%	85.8%	1.8%	-2.1%
Childhood Immunization Status (VZV)	91.0%	90.6%	-0.4%	82.6%	-8.8%	86.6%	4.8%	85.6%	-1.1%	-6.0%
Childhood Immunization Status (Pneumo- coccal Conjugate)	80.2%	79.8%	-0.5%	68.3%	-14.4%	75.2%	10.0%	74.8%	-0.5%	-6.8%
Childhood Immunization Status (Hepatitis A)	87.1%	87.9%	0.9%	81.2%	-7.5%	85.0%	4.6%	84.2%	-1.0%	-3.3%
Childhood Immunization Status (Rotavirus)	73.3%	75.0%	2.3%	64.5%	-14.0%	71.2%	10.5%	74.0%	3.8%	0.9%
Childhood Immunization Status (Influenza)	54.5%	52.7%	-3.3%	45.6%	-13.5%	45.3%	-0.5%	49.7%	9.6%	-8.8%
Childhood Immunization Status (Combination 2)	74.9%	75.0%	0.2%	64.0%	-14.7%	69.4%	8.4%	70.6%	1.7%	-5.7%
Childhood Immunization Status (Combination 3)	71.1%	71.7%	0.8%	60.9%	-14.9%	66.7%	9.5%	67.1%	0.6%	-5.6%
Childhood Immunization Status (Combination 4)	68.7%	69.4%	1.0%	59.3%	-14.6%	65.4%	10.3%	66.1%	1.0%	-3.9%
Childhood Immunization Status (Combination 5)	59.9%	61.6%	3.0%	52.7%	-14.6%	59.0%	12.1%	60.5%	2.6%	1.1%
Childhood Immunization Status (Combination 6)	45.5%	44.5%	-2.3%	38.0%	-14.5%	38.4%	1.1%	41.6%	8.3%	-8.6%
Childhood Immunization Status (Combination 7)	58.4%	59.9%	2.7%	51.1%	-14.7%	57.9%	13.2%	59.8%	3.3%	2.4%
Childhood Immunization Status (Combination 8)	44.5%	43.9%	-1.4%	37.3%	-14.9%	38.1%	2.1%	41.4%	8.6%	-7.0%
Childhood Immunization Status (Combination 9)	39.9%	39.8%	-0.3%	33.6%	-15.6%	35.0%	4.4%	38.1%	8.6%	-4.6%
Childhood Immunization Status (Combination 10)	39.2%	39.3%	0.1%	32.9%	-16.1%	34.9%	5.9%	38.0%	8.8%	-3.2%

Immunizations for Adolescents (Measure 17)[180]

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4
Immunizations for Adolescents	**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)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**
Presbyterian Health Plan										
Immunizations for Adolescents (Meningococcal)	67.8%	67.1%	-1.1%	60.4%	-10.0%	71.1%	17.7%	67.9%	-4.5%	0.1%
Immunizations for Adolescents (Tdap/Td)	78.9%	78.7%	-0.3%	73.9%	-6.1%	83.3%	12.7%	77.4%	-7.2%	-2.0%
Immunizations for Adolescents (Combination 1)	63.4%	64.9%	2.2%	58.9%	-9.2%	69.9%	18.7%	65.0%	-7.1%	2.4%
Immunizations for Adolescents (HPV)	NR	NR	N/A	NR	N/A	24.1%	N/A	27.7%	15.2%	N/A
Immunizations for Adolescents (Combination 2)	NR	NR	N/A	NR	N/A	22.5%	N/A	25.3%	12.7%	N/A
Molina Healthcare of New Mexico, Inc.										
Immunizations for Adolescents (Meningococcal)	62.3%	63.9%	2.6%	76.2%	19.2%	77.7%	2.0%	77.1%	-0.7%	23.8%
Immunizations for Adolescents (Tdap/Td)	78.5%	75.9%	-3.3%	85.4%	12.6%	90.1%	5.4%	87.6%	-2.7%	11.6%
Immunizations for Adolescents (Combination 1)	60.2%	61.1%	1.6%	73.8%	20.8%	76.4%	3.4%	75.7%	-0.9%	25.7%
Immunizations for Adolescents (HPV)	NR	NR	N/A	NR	N/A	25.4%	N/A	36.5%	43.8%	N/A
Immunizations for Adolescents (Combination 2)	NR	NR	N/A	NR	N/A	24.5%	N/A	34.3%	40.0%	N/A
Blue Cross and Blue Shield of New Mexico										
Immunizations for Adolescents (Meningococcal)	NR	39.1%	N/A	39.2%	0.2%	66.0%	68.4%	66.9%	1.4%	N/A
Immunizations for Adolescents (Tdap/Td)	NR	42.2%	N/A	43.5%	3.2%	82.3%	89.2%	79.3%	-3.7%	N/A
Immunizations for Adolescents (Combination 1)	NR	33.9%	N/A	34.6%	2.0%	65.1%	88.3%	65.7%	0.9%	N/A
Immunizations for Adolescents (HPV)	NR	NR	N/A	NR	N/A	19.2%	N/A	28.0%	45.7%	N/A
Immunizations for Adolescents (Combination 2)	NR	NR	N/A	NR	N/A	18.3%	N/A	25.1%	36.8%	N/A
United Healthcare of New Mexico, Inc.										
Immunizations for Adolescents (Meningococcal)	NR	33.3%	N/A	43.6%	30.7%	64.0%	46.9%	56.4%	-11.8%	N/A
Immunizations for Adolescents (Tdap/Td)	NR	53.3%	N/A	49.4%	-7.4%	79.3%	60.6%	76.2%	-4.0%	N/A
Immunizations for Adolescents (Combination 1)	NR	33.3%	N/A	40.6%	21.9%	62.8%	54.5%	54.5%	-13.2%	N/A
Immunizations for Adolescents (HPV)	NR	NR	N/A	NR	N/A	16.3%	N/A	23.8%	46.3%	N/A
Immunizations for Adolescents (Combination 2)	NR	NR	N/A	NR	N/A	14.6%	N/A	20.0%	36.7%	N/A
Total										
Immunizations for Adolescents (Meningococcal)	65.1%	64.3%	-1.2%	60.3%	-6.3%	69.8%	15.8%	67.1%	-3.9%	3.1%
Immunizations for Adolescents (Tdap/Td)	78.5%	76.4%	-2.7%	69.8%	-8.6%	83.9%	20.2%	80.1%	-4.5%	2.0%
Immunizations for Adolescents (Combination 1)	61.6%	61.9%	0.5%	58.1%	-6.2%	68.7%	18.3%	65.2%	-5.0%	5.9%
Immunizations for Adolescents (HPV)	NR	NR	N/A	NR	N/A	21.3%	N/A	29.0%	36.0%	N/A
Immunizations for Adolescents (Combination 2)	NR	NR	N/A	NR	N/A	20.1%	N/A	26.2%	30.3%	N/A

[180] 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. The "HPV" and "Combination 2" subcomponents are new to the HEDIS measure as of measurement year 2016 (DY3 Centennial Care).

Well-Child Visits in the First 15 Months of Life (Measure 18)[181]

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4
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)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/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%	52.2%	8.2%	56.3%	7.8%	-11.2%
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%	59.2%	6.8%	70.4%	18.9%	12.6%
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%	58.4%	21.8%	59.0%	1.1%	-5.3%
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	68.9%	20.9%	71.3%	3.5%	N/A

Well-Child Visits in Third, Fourth, Fifth and Sixth Years of Life (Measure 19)[182]

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4	DY1 to DY4
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)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**	**Change (p_4/p_1-1)**
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%	55.6%	1.4%	56.8%	2.2%	-14.8%	3.4%
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%	64.4%	-6.4%	67.6%	5.0%	1.7%	6.4%
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%	55.8%	-3.0%	57.2%	2.5%	-4.9%	1.0%
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%	53.5%	1.9%	57.2%	6.8%	N/A	-13.3%

[181] DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.
[182] DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Adolescent Well Care Visits (Measure 20)[183]

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4	DY1 to DY4
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)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**	**Change (p_4/p_1-1)**
Presbyterian Health Plan											
Adolescent well care visits	48.1%	36.4%	-24.5%	32.3%	-11.3%	33.1%	2.5%	33.4%	1.1%	-30.6%	-8.1%
Molina Healthcare of New Mexico, Inc.											
Adolescent well care visits	50.8%	51.7%	1.7%	45.9%	-11.1%	47.7%	3.8%	48.4%	1.5%	-4.6%	-6.3%
Blue Cross and Blue Shield of New Mexico											
Adolescent well care visits	39.0%	36.3%	-6.8%	33.1%	-8.9%	32.3%	-2.4%	33.4%	3.4%	-14.4%	-8.1%
United Healthcare of New Mexico, Inc.											
Adolescent well care visits	NR	31.1%	N/A	37.2%	19.5%	32.1%	-13.7%	43.6%	35.6%	N/A	39.8%

Prenatal and Postpartum Care (Measure 21 & Measure 82)[184]

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4
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)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**
Presbyterian Health Plan										
Postpartum Care	57.9%	61.9%	6.9%	53.1%	-14.1%	59.5%	12.0%	59.3%	-0.3%	2.4%
Timeliness of Prenatal Care	80.0%	77.9%	-2.7%	66.4%	-14.8%	79.9%	20.3%	71.4%	-10.6%	-10.9%
Molina Healthcare of New Mexico, Inc.										
Postpartum Care	62.9%	54.5%	-13.4%	51.5%	-5.5%	54.8%	6.5%	52.3%	-4.5%	-16.8%
Timeliness of Prenatal Care	89.2%	76.8%	-13.9%	76.0%	-1.1%	77.4%	1.9%	73.3%	-5.2%	-17.7%
Blue Cross and Blue Shield of New Mexico										
Postpartum Care	63.1%	54.5%	-13.5%	57.9%	6.2%	58.1%	0.3%	61.1%	5.2%	-3.1%
Timeliness of Prenatal Care	86.1%	73.1%	-15.1%	72.6%	-0.6%	75.5%	4.0%	78.6%	4.1%	-8.7%
United Healthcare of New Mexico, Inc.										
Postpartum Care	NR	48.2%	N/A	41.4%	-14.1%	59.1%	42.9%	56.2%	-4.9%	N/A
Timeliness of Prenatal Care	NR	63.7%	N/A	67.4%	5.7%	74.2%	10.1%	68.9%	-7.2%	N/A
Total										
Postpartum Care	61.3%	54.8%	-10.5%	51.2%	-6.7%	57.8%	13.0%	57.2%	-1.1%	-6.6%
Timeliness of Prenatal Care	84.8%	73.0%	-13.9%	70.7%	-3.2%	76.8%	8.6%	73.1%	-4.8%	-13.8%

[183] UHC baseline numerator and denominator were included in the calculation of aggregate rates; "NR" is shown since the denominator was less than 30.
[184] 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 & Measure 82)[185]

	Baseline	DY1		DY2		DY3		Baseline to DY3	DY1 to DY3
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)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Change (p_3/p_0-1)**	**Change (p_4/p_1-1)**
Presbyterian Health Plan									
Frequency of Ongoing Prenatal Care (<21%)	9.3%	13.6%	47.4%	21.3%	56.4%	11.2%	-47.3%	21.4%	-17.6%
Frequency of Ongoing Prenatal Care (21-40%)	10.6%	12.5%	17.1%	10.9%	-12.6%	9.8%	-9.8%	-7.6%	-21.1%
Frequency of Ongoing Prenatal Care (41-60%)	9.3%	12.7%	37.2%	10.7%	-16.0%	7.5%	-29.8%	-19.1%	-41.0%
Frequency of Ongoing Prenatal Care (61-80%)	13.9%	12.5%	-10.2%	14.2%	13.5%	16.6%	17.5%	19.7%	33.3%
Frequency of Ongoing Prenatal Care (>= 81%)	56.9%	48.7%	-14.5%	42.9%	-11.9%	54.8%	27.7%	-3.8%	12.5%
Molina Healthcare of New Mexico, Inc.									
Frequency of Ongoing Prenatal Care (<21%)	4.0%	9.0%	124.2%	7.6%	-16.2%	7.4%	-2.2%	83.7%	-18.1%
Frequency of Ongoing Prenatal Care (21-40%)	3.5%	7.7%	115.9%	7.8%	1.6%	8.1%	3.5%	127.1%	5.2%
Frequency of Ongoing Prenatal Care (41-60%)	5.7%	8.3%	46.9%	10.3%	23.6%	10.1%	-2.2%	77.4%	20.8%
Frequency of Ongoing Prenatal Care (61-80%)	13.5%	14.0%	3.6%	19.0%	36.0%	17.0%	-10.5%	26.2%	21.8%
Frequency of Ongoing Prenatal Care (>= 81%)	73.3%	61.0%	-16.7%	55.4%	-9.3%	57.5%	3.8%	-21.5%	-5.8%
Blue Cross and Blue Shield of New Mexico									
Frequency of Ongoing Prenatal Care (<21%)	7.7%	16.1%	107.4%	11.6%	-27.9%	11.7%	1.0%	51.1%	-27.2%
Frequency of Ongoing Prenatal Care (21-40%)	6.0%	7.7%	28.8%	10.7%	39.0%	8.6%	-19.5%	44.1%	11.9%
Frequency of Ongoing Prenatal Care (41-60%)	9.3%	6.6%	-29.4%	11.1%	69.7%	9.9%	-10.8%	6.9%	51.4%
Frequency of Ongoing Prenatal Care (61-80%)	16.2%	14.5%	-10.3%	16.0%	10.7%	13.9%	-13.3%	-13.9%	-4.0%
Frequency of Ongoing Prenatal Care (>= 81%)	60.8%	55.2%	-9.3%	50.6%	-8.4%	55.8%	10.5%	-8.2%	1.2%
United Healthcare of New Mexico, Inc.									
Frequency of Ongoing Prenatal Care (<21%)	NR	20.7%	N/A	20.4%	-1.2%	10.0%	-51.2%	N/A	-51.8%
Frequency of Ongoing Prenatal Care (21-40%)	NR	12.2%	N/A	23.1%	90.0%	9.2%	-60.0%	N/A	-24.0%
Frequency of Ongoing Prenatal Care (41-60%)	NR	11.2%	N/A	10.5%	-6.5%	10.0%	-4.7%	N/A	-10.9%
Frequency of Ongoing Prenatal Care (61-80%)	NR	13.4%	N/A	11.9%	-10.9%	15.8%	32.7%	N/A	18.2%
Frequency of Ongoing Prenatal Care (>= 81%)	NR	42.6%	N/A	34.1%	-20.0%	55.0%	61.4%	N/A	29.1%
Total									
Frequency of Ongoing Prenatal Care (<21%)	7.4%	14.8%	100.1%	15.1%	2.4%	10.1%	-33.3%	36.6%	-31.7%
Frequency of Ongoing Prenatal Care (21-40%)	6.8%	9.9%	45.2%	13.0%	30.5%	8.9%	-31.2%	30.4%	-10.2%
Frequency of Ongoing Prenatal Care (41-60%)	8.1%	9.6%	19.7%	10.6%	10.5%	9.4%	-11.9%	16.4%	-2.7%
Frequency of Ongoing Prenatal Care (61-80%)	14.5%	13.6%	-6.4%	15.3%	12.9%	15.8%	3.2%	9.0%	16.4%
Frequency of Ongoing Prenatal Care (>= 81%)	63.2%	52.1%	-17.6%	45.9%	-11.8%	55.8%	21.5%	-11.7%	7.1%

[185] 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)[186]

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4
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)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**
Presbyterian Health Plan										
Breast cancer screening	54.6%	49.7%	-9.0%	44.4%	-10.7%	45.3%	2.2%	46.5%	2.6%	-14.8%
Molina Healthcare of New Mexico, Inc.										
Breast cancer screening	67.0%	71.4%	6.6%	63.5%	-11.1%	56.6%	-10.9%	55.9%	-1.2%	-16.6%
Blue Cross and Blue Shield of New Mexico										
Breast cancer screening	51.4%	51.2%	-0.4%	54.6%	6.5%	41.6%	-23.7%	41.9%	0.7%	-18.5%
United Healthcare of New Mexico, Inc.										
Breast cancer screening	44.4%	36.7%	-17.3%	38.9%	6.0%	44.8%	15.2%	53.9%	20.3%	21.4%
Total										
Breast cancer screening	54.5%	52.5%	-3.7%	50.7%	-3.3%	47.2%	-6.9%	49.5%	4.8%	-9.1%

Cervical Cancer Screening for Women (Measure 24)[187]

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4
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)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**
Presbyterian Health Plan										
Cervical cancer screening	65.0%	57.3%	-12.0%	56.4%	-1.5%	57.2%	1.4%	53.8%	-5.9%	-17.2%
Molina Healthcare of New Mexico, Inc.										
Cervical cancer screening	66.7%	45.8%	-31.3%	52.7%	15.1%	58.7%	11.4%	57.9%	-1.4%	-13.2%
Blue Cross and Blue Shield of New Mexico										
Cervical cancer screening	48.0%	28.4%	-41.0%	45.8%	61.5%	52.5%	14.8%	50.6%	-3.7%	5.3%
United Healthcare of New Mexico, Inc.										
Cervical cancer screening	43.1%	27.3%	-36.7%	39.7%	45.5%	45.3%	14.1%	40.4%	-10.8%	-6.3%
Total										
Cervical cancer screening	58.4%	43.2%	-26.0%	48.7%	12.7%	53.5%	10.0%	54.1%	1.0%	-7.4%

[186] DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.
[187] 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		DY3		DY4		DY1 to DY4
Initiation and engagement of alcohol and other drug dependence treatment	**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)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_1-1)**
Presbyterian Health Plan									
Initiation of AOD Treatment (13-17 Yrs)	36.6%	N/A	46.1%	25.9%	37.4%	-18.7%	40.6%	8.6%	11.1%
Initiation of AOD Treatment (18+ Yrs)	36.7%	N/A	39.6%	8.0%	36.7%	-7.4%	39.5%	7.5%	7.6%
Initiation of AOD Treatment (Total)	36.7%	N/A	40.2%	9.7%	36.8%	-8.6%	39.6%	7.6%	7.8%
Engagement of AOD Treatment (13-17 Yrs)	15.0%	N/A	21.5%	43.2%	15.2%	-29.0%	15.2%	-0.4%	1.2%
Engagement of AOD Treatment (18+ Yrs)	14.0%	N/A	14.7%	5.0%	14.0%	-4.9%	15.3%	9.7%	9.5%
Engagement of AOD Treatment (Total)	14.1%	N/A	15.3%	8.5%	14.1%	-8.2%	15.3%	8.9%	8.4%
Molina Healthcare of New Mexico, Inc.									
Initiation of AOD Treatment (13-17 Yrs)	46.6%	N/A	44.8%	-3.9%	43.5%	-2.9%	41.6%	-4.4%	-10.8%
Initiation of AOD Treatment (18+ Yrs)	38.9%	N/A	34.9%	-10.2%	36.7%	5.1%	39.6%	7.8%	1.8%
Initiation of AOD Treatment (Total)	39.5%	N/A	35.6%	-9.9%	37.2%	4.3%	39.7%	6.9%	0.5%
Engagement of AOD Treatment (13-17 Yrs)	17.6%	N/A	16.8%	-4.6%	12.5%	-25.5%	11.8%	-5.9%	-33.1%
Engagement of AOD Treatment (18+ Yrs)	13.1%	N/A	11.7%	-10.7%	12.3%	5.5%	14.8%	20.2%	13.3%
Engagement of AOD Treatment (Total)	13.5%	N/A	12.0%	-10.5%	12.3%	2.4%	14.6%	18.5%	8.6%
Blue Cross and Blue Shield of New Mexico									
Initiation of AOD Treatment (13-17 Yrs)	51.6%	N/A	46.6%	-9.7%	36.7%	-21.1%	49.7%	35.3%	-3.6%
Initiation of AOD Treatment (18+ Yrs)	39.0%	N/A	37.0%	-4.9%	36.3%	-2.1%	40.0%	10.4%	2.8%
Initiation of AOD Treatment (Total)	39.5%	N/A	37.3%	-5.4%	36.3%	-2.8%	40.3%	11.0%	2.1%
Engagement of AOD Treatment (13-17 Yrs)	25.0%	N/A	16.2%	-35.3%	7.9%	-51.1%	16.4%	106.7%	-34.6%
Engagement of AOD Treatment (18+ Yrs)	14.2%	N/A	14.2%	0.0%	14.6%	2.2%	15.5%	6.5%	8.9%
Engagement of AOD Treatment (Total)	14.7%	N/A	14.3%	-2.4%	14.4%	0.6%	15.5%	7.9%	6.0%
United Healthcare of New Mexico, Inc.									
Initiation of AOD Treatment (13-17 Yrs)	NR	N/A	NR	N/A	50.6%	N/A	52.3%	3.3%	N/A
Initiation of AOD Treatment (18+ Yrs)	NR	N/A	NR	N/A	46.7%	N/A	39.2%	-16.0%	N/A
Initiation of AOD Treatment (Total)	NR	N/A	NR	N/A	46.7%	N/A	39.4%	-15.7%	N/A
Engagement of AOD Treatment (13-17 Yrs)	NR	N/A	NR	N/A	16.5%	N/A	13.8%	-15.9%	N/A
Engagement of AOD Treatment (18+ Yrs)	NR	N/A	NR	N/A	14.9%	N/A	13.9%	-6.7%	N/A
Engagement of AOD Treatment (Total)	NR	N/A	NR	N/A	14.9%	N/A	13.9%	-6.9%	N/A
Total									
Initiation of AOD Treatment (13-17 Yrs)	42.3%	N/A	45.6%	7.7%	40.5%	-11.1%	42.7%	5.4%	0.9%
Initiation of AOD Treatment (18+ Yrs)	38.2%	N/A	37.1%	-2.9%	38.5%	3.9%	39.6%	2.8%	3.6%
Initiation of AOD Treatment (Total)	38.6%	N/A	37.7%	-2.4%	38.6%	2.6%	39.8%	2.9%	3.1%
Engagement of AOD Treatment (13-17 Yrs)	17.2%	N/A	18.9%	9.8%	13.2%	-29.8%	13.9%	4.6%	-19.4%
Engagement of AOD Treatment (18+ Yrs)	13.7%	N/A	13.5%	-1.6%	13.8%	2.7%	15.0%	8.3%	9.5%
Engagement of AOD Treatment (Total)	14.0%	N/A	13.8%	-1.2%	13.8%	-0.1%	14.9%	8.1%	6.7%

Number and Percentage of Participants in Nursing Facility (NF) Transitioning to Community (HCBS) (Measure 35)

	DY1		DY2		DY3		DY4		DY1 to DY4
Number and percentage of participants in Nursing Facility (NF) transitioning to community (HCBS)	**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)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_1-1)**
Presbyterian Health Plan									
Member Who Left NF and Moved to Community	2.5%	N/A	4.8%	93.4%	3.9%	-18.1%	3.1%	-20.1%	26.6%
Members Readmittd to NF	0.0%	N/A	0.3%	N/A	0.3%	13.9%	0.0%	-100.0%	N/A
Molina Healthcare of New Mexico, Inc.									
Member Who Left NF and Moved to Community	4.8%	N/A	3.5%	-27.2%	4.5%	29.8%	1.9%	-58.1%	-60.5%
Members Readmittd to NF	0.5%	N/A	0.3%	-40.9%	0.6%	86.6%	0.2%	-72.1%	-69.3%
Blue Cross and Blue Shield of New Mexico									
Member Who Left NF and Moved to Community	1.8%	N/A	1.9%	1.5%	3.8%	104.5%	4.1%	6.8%	121.6%
Members Readmittd to NF	0.3%	N/A	0.5%	48.8%	2.1%	311.9%	0.5%	-77.4%	38.5%
United Healthcare of New Mexico, Inc.									
Member Who Left NF and Moved to Community	1.1%	N/A	0.9%	-19.9%	0.7%	-18.7%	1.3%	82.6%	18.9%
Members Readmittd to NF	0.1%	N/A	0.2%	67.6%	0.1%	-25.5%	0.4%	192.2%	264.8%
Total									
Member Who Left NF and Moved to Community	2.0%	N/A	1.8%	-8.5%	2.6%	44.4%	2.2%	-16.2%	10.7%
Members Readmittd to NF	0.2%	N/A	0.3%	28.6%	0.7%	179.1%	0.3%	-65.6%	23.3%

Annual Monitoring Persistent Medications (Measure 38)[188]

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4
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)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/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%	83.8%	0.4%	84.3%	0.6%	-0.5%
Annual monitoring for patients on persistent Digoxin	NR	NR	N/A	NR	N/A	47.1%	N/A	NR	N/A	N/A
Annual monitoring for patients on Diuretics	87.8%	84.8%	-3.4%	85.8%	1.2%	84.4%	-1.6%	85.2%	1.0%	-3.0%
Annual monitoring for patients: Total	85.9%	84.0%	-2.2%	84.1%	0.1%	83.8%	-0.3%	84.6%	0.9%	-1.5%
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%	83.3%	0.8%	82.9%	-0.5%	-4.9%
Annual monitoring for patients on persistent Digoxin	NR	60.0%	N/A	42.9%	-28.6%	NR	N/A	NR	N/A	N/A
Annual monitoring for patients on Diuretics	88.9%	83.2%	-6.4%	83.5%	0.3%	84.1%	0.7%	84.2%	0.1%	-5.3%
Annual monitoring for patients: Total	87.8%	83.1%	-5.4%	82.8%	-0.3%	83.5%	0.8%	83.4%	-0.1%	-5.0%
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%	83.3%	0.7%	81.8%	-1.8%	-8.8%
Annual monitoring for patients on persistent Digoxin	NR	NR	N/A	NR	N/A	NR	N/A	NR	N/A	N/A
Annual monitoring for patients on Diuretics	89.8%	85.2%	-5.1%	83.3%	-2.2%	84.7%	1.7%	84.2%	-0.6%	-6.2%
Annual monitoring for patients: Total	89.6%	85.0%	-5.2%	82.8%	-2.5%	83.7%	1.1%	82.7%	-1.2%	-7.8%
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%	83.3%	0.3%	84.6%	1.5%	-4.5%
Annual monitoring for patients on persistent Digoxin	NR	NR	N/A	NR	N/A	57.5%	N/A	NR	N/A	N/A
Annual monitoring for patients on Diuretics	91.5%	86.4%	-5.5%	84.9%	-1.8%	83.9%	-1.2%	87.2%	3.9%	-4.8%
Annual monitoring for patients: Total	89.9%	85.3%	-5.1%	83.5%	-2.1%	83.4%	-0.2%	85.5%	2.5%	-4.9%
Total										
Annual monitoring for patients on ACE Inhibitors or ARBs	86.6%	83.9%	-3.0%	82.9%	-1.2%	83.4%	0.6%	83.4%	0.0%	-3.6%
Annual monitoring for patients on persistent Digoxin	85.4%	54.3%	-36.4%	42.0%	-22.8%	50.8%	21.0%	NR	N/A	N/A
Annual monitoring for patients on Diuretics	89.0%	84.5%	-5.1%	84.3%	-0.2%	84.2%	-0.1%	85.2%	1.1%	-4.4%
Annual monitoring for patients: Total	87.5%	84.0%	-4.0%	83.3%	-0.9%	83.6%	0.4%	84.0%	0.5%	-4.0%

[188] 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)[189]

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4
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)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**
Presbyterian Health Plan										
5-11 Years - Medication Compliance 50%	47.9%	45.5%	-5.0%	53.4%	17.4%	50.8%	-5.0%	54.0%	6.4%	12.6%
12-18 Years - Medication Compliance 50%	42.7%	40.6%	-4.9%	48.9%	20.4%	47.4%	-3.0%	50.9%	7.3%	19.2%
19-50 Years - Medication Compliance 50%	47.4%	51.2%	8.1%	59.8%	16.8%	59.5%	-0.5%	63.9%	7.4%	34.9%
51-64 Years - Medication Compliance 50%	71.4%	56.8%	-20.5%	72.5%	27.7%	66.7%	-8.0%	78.3%	17.5%	9.6%
Total - Medication Compliance 50%	46.4%	44.7%	-3.6%	54.6%	22.0%	52.9%	-3.0%	57.5%	8.6%	23.9%
Molina Healthcare of New Mexico, Inc.										
5-11 Years - Medication Compliance 50%	44.1%	46.2%	4.8%	46.2%	0.0%	46.5%	0.5%	51.9%	11.6%	17.6%
12-18 Years - Medication Compliance 50%	42.7%	44.2%	3.7%	41.5%	-6.1%	44.4%	7.0%	49.5%	11.5%	16.1%
19-50 Years - Medication Compliance 50%	48.5%	47.9%	-1.3%	56.2%	17.3%	54.5%	-3.0%	59.3%	8.9%	22.3%
51-64 Years - Medication Compliance 50%	NR	56.6%	N/A	71.0%	25.6%	72.8%	2.5%	68.1%	-6.4%	N/A
Total - Medication Compliance 50%	44.8%	47.0%	5.0%	49.4%	5.0%	50.8%	2.8%	55.1%	8.5%	23.0%
Blue Cross and Blue Shield of New Mexico										
5-11 Years - Medication Compliance 50%	43.6%	43.9%	0.6%	45.1%	2.8%	52.3%	15.9%	54.9%	4.9%	25.8%
12-18 Years - Medication Compliance 50%	43.3%	48.2%	11.3%	35.8%	-25.8%	39.9%	11.6%	39.9%	0.0%	-7.9%
19-50 Years - Medication Compliance 50%	62.5%	55.3%	-11.6%	59.6%	7.8%	58.8%	-1.4%	50.5%	-14.0%	-19.2%
51-64 Years - Medication Compliance 50%	NR	NR	N/A	66.7%	N/A	72.4%	8.7%	60.8%	-16.1%	N/A
Total - Medication Compliance 50%	48.5%	49.5%	2.1%	51.1%	3.2%	56.0%	9.6%	51.5%	-8.0%	6.2%
United Healthcare of New Mexico, Inc.										
5-11 Years - Medication Compliance 50%	NR	NR	N/A	31.6%	N/A	48.2%	52.7%	46.8%	-2.9%	N/A
12-18 Years - Medication Compliance 50%	NR	NR	N/A	36.7%	N/A	45.5%	24.0%	48.7%	7.2%	N/A
19-50 Years - Medication Compliance 50%	NR	NR	N/A	56.7%	N/A	64.0%	13.0%	64.7%	1.0%	N/A
51-64 Years - Medication Compliance 50%	NR	63.3%	N/A	67.7%	6.9%	74.5%	10.0%	75.0%	0.7%	N/A
Total - Medication Compliance 50%	64.9%	67.2%	3.7%	56.3%	-16.3%	64.2%	14.0%	64.8%	1.0%	-0.1%
Total										
5-11 Years - Medication Compliance 50%	46.5%	45.6%	-2.0%	49.1%	7.7%	49.3%	0.3%	53.2%	7.9%	14.3%
12-18 Years - Medication Compliance 50%	42.7%	42.2%	-1.1%	44.1%	4.4%	45.3%	2.8%	48.9%	7.9%	14.5%
19-50 Years - Medication Compliance 50%	50.0%	51.0%	2.0%	58.2%	14.1%	58.2%	0.1%	59.3%	1.9%	18.7%
51-64 Years - Medication Compliance 50%	69.7%	59.4%	-14.7%	69.6%	17.2%	71.7%	2.9%	69.9%	-2.5%	0.4%
Total - Medication Compliance 50%	46.3%	46.3%	-0.1%	52.2%	12.8%	53.5%	2.5%	56.0%	4.7%	20.9%

[189] 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)[190]

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4
Asthma Medication Ratio	**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)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**
Presbyterian Health Plan										
Asthma Medication Ratio (5-11)	71.7%	62.3%	-13.1%	67.3%	8.1%	71.3%	5.9%	67.9%	-4.7%	-5.2%
Asthma Medication Ratio (12-18)	54.0%	47.7%	-11.6%	50.9%	6.7%	54.8%	7.6%	57.5%	5.0%	6.6%
Asthma Medication Ratio (19-50)	36.4%	34.1%	-6.2%	43.6%	27.8%	40.4%	-7.4%	45.9%	13.4%	26.0%
Asthma Medication Ratio (51-64)	34.5%	34.8%	0.9%	50.6%	45.4%	48.3%	-4.6%	51.5%	6.8%	49.5%
Asthma Medication Ratio: Total	59.3%	51.5%	-13.2%	54.2%	5.2%	55.8%	2.9%	56.7%	1.6%	-4.5%
Molina Healthcare of New Mexico, Inc.										
Asthma Medication Ratio (5-11)	69.2%	60.9%	-12.0%	74.7%	22.5%	72.5%	-3.0%	75.2%	3.7%	8.6%
Asthma Medication Ratio (12-18)	58.5%	51.7%	-11.7%	57.1%	10.5%	57.8%	1.3%	55.1%	-4.7%	-5.8%
Asthma Medication Ratio (19-50)	43.6%	44.4%	1.8%	49.9%	12.4%	47.2%	-5.5%	49.8%	5.5%	14.1%
Asthma Medication Ratio (51-64)	31.0%	49.6%	60.4%	51.4%	3.6%	57.7%	12.2%	54.8%	-4.9%	77.1%
Asthma Medication Ratio: Total	60.1%	53.0%	-11.8%	61.2%	15.5%	59.6%	-2.6%	59.6%	0.1%	-0.8%
Blue Cross and Blue Shield of New Mexico										
Asthma Medication Ratio (5-11)	85.6%	62.5%	-27.0%	66.3%	6.1%	74.6%	12.5%	77.0%	3.3%	-10.0%
Asthma Medication Ratio (12-18)	65.2%	47.0%	-28.0%	53.6%	14.1%	61.3%	14.5%	57.4%	-6.5%	-12.0%
Asthma Medication Ratio (19-50)	70.2%	55.6%	-20.9%	50.1%	-9.8%	48.5%	-3.2%	41.5%	-14.4%	-40.8%
Asthma Medication Ratio (51-64)	NR	NR	N/A	60.5%	N/A	55.8%	-7.8%	53.4%	-4.2%	N/A
Asthma Medication Ratio: Total	74.8%	55.0%	-26.4%	56.8%	3.3%	58.0%	2.1%	54.5%	-6.1%	-27.1%
United Healthcare of New Mexico, Inc.										
Asthma Medication Ratio (5-11)	NR	NR	N/A	70.0%	N/A	70.0%	0.0%	75.0%	7.1%	N/A
Asthma Medication Ratio (12-18)	NR	NR	N/A	55.9%	N/A	56.1%	0.4%	53.7%	-4.3%	N/A
Asthma Medication Ratio (19-50)	36.7%	46.7%	27.3%	42.4%	-9.2%	44.7%	5.4%	49.8%	11.6%	35.9%
Asthma Medication Ratio (51-64)	42.4%	51.2%	20.7%	48.2%	-6.0%	52.0%	8.0%	56.7%	9.1%	33.7%
Asthma Medication Ratio: Total	40.0%	49.4%	23.6%	47.7%	-3.5%	50.3%	5.5%	54.5%	8.4%	36.3%
Total										
Asthma Medication Ratio (5-11)	71.9%	61.9%	-13.9%	70.2%	13.5%	72.2%	2.7%	72.3%	0.2%	0.6%
Asthma Medication Ratio (12-18)	55.9%	48.9%	-12.5%	53.8%	9.9%	56.8%	5.5%	56.5%	-0.4%	1.1%
Asthma Medication Ratio (19-50)	41.8%	40.6%	-3.0%	46.8%	15.4%	44.9%	-4.1%	46.5%	3.5%	11.1%
Asthma Medication Ratio (51-64)	36.6%	45.6%	24.6%	52.4%	14.8%	53.9%	2.9%	54.1%	0.3%	47.6%
Asthma Medication Ratio: Total	60.2%	52.2%	-13.3%	56.8%	8.7%	57.1%	0.5%	57.1%	0.1%	-5.2%

[190] 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)[191]

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4	DY1 to DY4
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)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**	**Change (p_4/p_1-1)**
Presbyterian Health Plan											
Adult BMI assessment	73.4%	84.3%	14.9%	83.9%	-0.5%	83.3%	-0.7%	84.2%	1.0%	14.7%	-0.2%
BMI Percentile (3-11 Yrs)	34.6%	44.7%	29.3%	61.7%	38.0%	59.3%	-3.9%	61.7%	4.1%	78.6%	38.1%
BMI Percentile (12-17 Yrs)	40.6%	40.8%	0.3%	64.8%	59.0%	66.9%	3.2%	69.0%	3.2%	69.9%	69.3%
BMI Percentile (Total)	36.8%	43.3%	17.5%	62.8%	45.1%	62.0%	-1.2%	64.2%	3.5%	74.5%	48.5%
Counseling for Nutrition (3-11 Yrs)	48.9%	55.7%	13.9%	51.8%	-6.9%	59.3%	14.4%	55.0%	-7.2%	12.5%	-1.2%
Counseling for Nutrition (12-17 Yrs)	43.1%	47.8%	10.8%	50.3%	5.4%	58.6%	16.4%	57.7%	-1.5%	33.9%	20.9%
Counseling for Nutrition (Total)	46.8%	52.8%	12.9%	51.3%	-2.8%	59.0%	15.0%	56.0%	-5.2%	19.7%	6.0%
Counseling for Physical Activity (3-11 Yrs)	38.2%	44.7%	16.9%	37.2%	-16.7%	49.1%	31.9%	40.5%	-17.5%	6.0%	-9.3%
Counseling for Physical Activity (12-17 Yrs)	40.0%	42.0%	5.1%	51.7%	23.0%	59.2%	14.5%	57.0%	-3.7%	42.6%	35.7%
Counseling for Physical Activity (Total)	38.9%	43.7%	12.4%	42.2%	-3.4%	52.8%	24.9%	46.2%	-12.4%	18.9%	5.7%
Molina Healthcare of New Mexico, Inc.											
Adult BMI assessment	81.0%	74.5%	-8.1%	79.7%	7.0%	79.3%	-0.4%	73.8%	-6.9%	-8.9%	-0.9%
BMI Percentile (3-11 Yrs)	57.8%	32.3%	-44.1%	53.7%	66.1%	63.4%	18.0%	61.9%	-2.3%	7.0%	91.5%
BMI Percentile (12-17 Yrs)	56.4%	40.0%	-29.1%	51.6%	29.1%	60.2%	16.7%	64.4%	6.9%	14.1%	61.0%
BMI Percentile (Total)	57.4%	35.0%	-39.1%	53.0%	51.6%	62.3%	17.5%	62.8%	0.8%	9.4%	79.6%
Counseling for Nutrition (3-11 Yrs)	51.1%	55.2%	8.0%	54.0%	-2.2%	55.1%	2.1%	56.2%	2.0%	10.0%	1.8%
Counseling for Nutrition (12-17 Yrs)	49.3%	49.7%	0.8%	50.3%	1.3%	55.9%	11.1%	53.4%	-4.4%	8.4%	7.5%
Counseling for Nutrition (Total)	50.6%	53.3%	5.5%	52.8%	-1.0%	55.4%	5.0%	55.2%	-0.3%	9.3%	3.6%
Counseling for Physical Activity (3-11 Yrs)	41.5%	50.2%	20.8%	49.3%	-1.7%	46.2%	-6.3%	49.4%	6.9%	19.0%	-1.5%
Counseling for Physical Activity (12-17 Yrs)	45.7%	47.7%	4.4%	49.7%	4.0%	61.5%	23.8%	55.5%	-9.8%	21.4%	16.2%
Counseling for Physical Activity (Total)	42.8%	49.3%	15.2%	49.4%	0.2%	51.7%	4.5%	51.6%	-0.1%	20.4%	4.6%
Blue Cross and Blue Shield of New Mexico											
Adult BMI assessment	71.7%	79.2%	10.6%	72.1%	-9.0%	76.2%	5.6%	79.6%	4.5%	11.0%	0.4%
BMI Percentile (3-11 Yrs)	52.9%	55.2%	4.3%	52.7%	-4.5%	59.2%	12.4%	65.1%	9.8%	22.9%	17.8%
BMI Percentile (12-17 Yrs)	46.2%	55.8%	20.9%	53.2%	-4.7%	57.6%	8.2%	57.7%	0.3%	25.1%	3.5%
BMI Percentile (Total)	51.0%	55.4%	8.7%	52.9%	-4.6%	58.8%	11.1%	62.5%	6.4%	22.6%	12.9%
Counseling for Nutrition (3-11 Yrs)	41.5%	57.1%	37.7%	43.4%	-24.0%	49.5%	14.1%	57.6%	16.3%	38.9%	0.8%
Counseling for Nutrition (12-17 Yrs)	36.2%	52.2%	44.3%	41.8%	-19.8%	47.7%	14.1%	47.9%	0.3%	32.5%	-8.2%
Counseling for Nutrition (Total)	40.0%	55.6%	39.2%	42.9%	-22.8%	49.0%	14.2%	54.3%	10.7%	35.8%	-2.5%
Counseling for Physical Activity (3-11 Yrs)	34.4%	48.9%	42.3%	38.6%	-21.1%	43.3%	12.1%	46.1%	6.6%	34.1%	-5.7%
Counseling for Physical Activity (12-17 Yrs)	37.7%	52.9%	40.3%	40.4%	-23.6%	49.2%	21.8%	51.4%	4.4%	36.4%	-2.8%
Counseling for Physical Activity (Total)	35.3%	50.1%	41.9%	39.2%	-21.9%	45.0%	14.9%	47.9%	6.5%	35.7%	-4.3%

[191] 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.

Adult BMI Assessment and Weight Assessment for Children/Adolescents (continued)

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4	DY1 to DY4
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)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**	**Change (p_4/p_1-1)**
United Healthcare of New Mexico, Inc.											
Adult BMI assessment	71.5%	74.5%	4.1%	71.7%	-3.8%	77.8%	8.6%	81.8%	5.1%	14.3%	9.8%
BMI Percentile (3-11 Yrs)	NR	43.8%	N/A	48.1%	9.9%	63.6%	32.1%	53.4%	-16.0%	N/A	21.9%
BMI Percentile (12-17 Yrs)	NR	43.8%	N/A	42.6%	-2.7%	58.0%	36.3%	56.0%	-3.5%	N/A	27.9%
BMI Percentile (Total)	NR	43.8%	N/A	46.2%	5.6%	61.6%	33.2%	54.3%	-11.9%	N/A	23.9%
Counseling for Nutrition (3-11 Yrs)	NR	53.4%	N/A	54.8%	2.7%	63.2%	15.3%	54.9%	-13.2%	N/A	2.8%
Counseling for Nutrition (12-17 Yrs)	NR	43.1%	N/A	52.5%	21.7%	56.0%	6.7%	46.3%	-17.4%	N/A	7.3%
Counseling for Nutrition (Total)	NR	49.4%	N/A	54.0%	9.4%	60.6%	12.2%	52.1%	-14.1%	N/A	5.4%
Counseling for Physical Activity (3-11 Yrs)	NR	31.5%	N/A	43.3%	37.7%	49.8%	14.9%	40.1%	-19.5%	N/A	27.3%
Counseling for Physical Activity (12-17 Yrs)	NR	40.6%	N/A	50.4%	23.9%	55.3%	9.9%	52.2%	-5.6%	N/A	28.6%
Counseling for Physical Activity (Total)	NR	35.0%	N/A	45.7%	30.6%	51.8%	13.3%	44.0%	-15.0%	N/A	25.7%
Total											
Adult BMI assessment	74.2%	78.2%	5.4%	76.0%	-2.8%	78.6%	3.5%	79.9%	1.6%	7.6%	2.1%
BMI Percentile (3-11 Yrs)	49.2%	44.2%	-10.1%	54.0%	22.3%	61.3%	13.4%	60.5%	-1.3%	22.9%	36.8%
BMI Percentile (12-17 Yrs)	47.4%	44.8%	-5.5%	53.1%	18.7%	60.8%	14.6%	61.9%	1.7%	30.6%	38.3%
BMI Percentile (Total)	48.6%	44.4%	-8.7%	53.7%	21.0%	61.1%	13.8%	60.9%	-0.3%	25.4%	37.3%
Counseling for Nutrition (3-11 Yrs)	47.4%	55.5%	16.9%	50.8%	-8.4%	56.4%	11.0%	55.9%	-0.9%	17.9%	0.8%
Counseling for Nutrition (12-17 Yrs)	43.5%	48.0%	10.4%	48.8%	1.6%	54.8%	12.4%	51.4%	-6.2%	18.2%	7.0%
Counseling for Nutrition (Total)	46.2%	52.9%	14.5%	50.1%	-5.1%	55.9%	11.4%	54.4%	-2.7%	17.8%	2.9%
Counseling for Physical Activity (3-11 Yrs)	38.3%	44.4%	15.9%	42.2%	-5.0%	46.9%	11.3%	44.0%	-6.2%	14.9%	-0.9%
Counseling for Physical Activity (12-17 Yrs)	41.2%	45.6%	10.5%	48.1%	5.6%	56.7%	17.8%	54.1%	-4.6%	31.2%	18.7%
Counseling for Physical Activity (Total)	39.2%	44.8%	14.2%	44.1%	-1.4%	50.3%	13.9%	47.4%	-5.6%	20.9%	5.9%

Annual Rate Data for Diabetes - annual recommended tests (A1C, LDL, eye exam, nephropathy exam (Measure 42 & 81)[192]

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4
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)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**
Presbyterian Health Plan										
HbA1c Testing	81.4%	86.5%	6.3%	84.6%	-2.2%	83.2%	-1.6%	84.9%	1.9%	4.2%
HbA1c Poor Control (>9.0%)	47.9%	43.9%	-8.3%	48.3%	10.1%	51.8%	7.1%	49.5%	-4.5%	3.2%
HbA1c Control (<8.0%)	42.8%	47.9%	12.0%	44.9%	-6.4%	40.5%	-9.6%	39.8%	-1.9%	-7.0%
Eye Exam	48.3%	47.8%	-1.0%	46.1%	-3.5%	51.8%	12.3%	52.0%	0.5%	7.8%
Medical Attention for Nephropathy	71.6%	79.5%	11.0%	86.9%	9.3%	87.6%	0.8%	86.1%	-1.7%	20.2%
Blood Pressure Controlled <140/90 mm Hg	63.7%	64.2%	0.9%	62.7%	-2.5%	57.1%	-8.8%	47.4%	-16.9%	-25.5%
Molina Healthcare of New Mexico, Inc.										
HbA1c Testing	85.1%	85.7%	0.6%	88.1%	2.8%	87.2%	-1.0%	87.1%	-0.1%	2.4%
HbA1c Poor Control (>9.0%)	41.8%	49.9%	19.5%	45.0%	-9.7%	41.1%	-8.8%	47.9%	16.7%	14.8%
HbA1c Control (<8.0%)	48.5%	37.7%	-22.2%	45.0%	19.3%	44.4%	-1.5%	39.7%	-10.6%	-18.3%
Eye Exam	58.2%	56.5%	-3.0%	54.5%	-3.5%	59.8%	9.7%	60.3%	0.9%	3.6%
Medical Attention for Nephropathy	78.1%	74.8%	-4.2%	88.1%	17.7%	89.0%	1.0%	88.6%	-0.4%	13.4%
Blood Pressure Controlled <140/90 mm Hg	64.3%	59.4%	-7.7%	62.0%	4.5%	63.1%	1.8%	58.2%	-7.9%	-9.6%
Blue Cross and Blue Shield of New Mexico										
HbA1c Testing	82.2%	83.4%	1.4%	80.4%	-3.6%	82.6%	2.6%	82.0%	-0.7%	-0.3%
HbA1c Poor Control (>9.0%)	53.6%	47.3%	-11.7%	52.9%	11.9%	48.6%	-8.2%	50.4%	3.7%	-6.0%
HbA1c Control (<8.0%)	36.3%	43.1%	18.7%	39.3%	-8.8%	41.9%	6.7%	39.7%	-5.4%	9.1%
Eye Exam	51.9%	54.2%	4.5%	47.8%	-11.9%	51.2%	7.2%	51.1%	-0.2%	-1.6%
Medical Attention for Nephropathy	75.4%	78.6%	4.2%	85.1%	8.2%	87.4%	2.8%	86.4%	-1.2%	14.5%
Blood Pressure Controlled <140/90 mm Hg	55.7%	57.4%	2.9%	55.9%	-2.6%	55.4%	-0.9%	48.7%	-12.2%	-12.7%
United Healthcare of New Mexico, Inc.										
HbA1c Testing	85.9%	84.4%	-1.7%	84.4%	0.0%	81.0%	-4.0%	89.3%	10.2%	4.0%
HbA1c Poor Control (>9.0%)	49.5%	49.1%	-0.8%	52.6%	6.9%	47.9%	-8.8%	45.5%	-5.1%	-8.2%
HbA1c Control (<8.0%)	41.9%	43.3%	3.4%	37.5%	-13.5%	43.8%	16.9%	45.3%	3.3%	8.0%
Eye Exam	44.0%	65.2%	48.3%	62.5%	-4.1%	60.6%	-3.1%	56.2%	-7.2%	27.8%
Medical Attention for Nephropathy	82.9%	83.7%	1.0%	90.3%	7.8%	91.5%	1.3%	89.8%	-1.9%	8.3%
Blood Pressure Controlled <140/90 mm Hg	62.5%	54.7%	-12.4%	52.3%	-4.4%	57.4%	9.8%	66.2%	15.3%	5.9%
Total										
HbA1c Testing	83.5%	85.0%	1.8%	84.1%	-1.0%	83.5%	-0.7%	85.7%	2.6%	2.7%
HbA1c Poor Control (>9.0%)	47.9%	47.2%	-1.5%	49.8%	5.4%	47.6%	-4.3%	48.4%	1.6%	1.0%
HbA1c Control (<8.0%)	42.7%	43.4%	1.6%	41.8%	-3.7%	42.5%	1.7%	41.0%	-3.5%	-4.0%
Eye Exam	50.4%	55.0%	9.2%	51.8%	-5.9%	55.4%	7.1%	54.7%	-1.3%	8.6%
Medical Attention for Nephropathy	76.6%	79.1%	3.3%	87.3%	10.4%	88.7%	1.6%	87.6%	-1.3%	14.4%
Blood Pressure Controlled <140/90 mm Hg	62.0%	59.3%	-4.4%	58.4%	-1.4%	58.2%	-0.4%	54.5%	-6.3%	-12.0%

[192] DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Centennial Care Evaluation

ACS admission rates for COPD or asthma in younger adults (Measure 44.a)

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4
Ambulatory care sensitive (ACS) admission rate: COPD or asthma in older 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)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**
Total										
Ambulatory care sensitive (ACS) admission rate: COPD or asthma in older adults	0.0%	0.0%	-26.4%	0.0%	-23.8%	0.0%	-10.8%	0.0%	-23.9%	-62.0%

ACS admission rates for COPD or asthma in older adults (Measure 44.b)

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4
Ambulatory care sensitive (ACS) admission rate: COPD or asthma in young 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)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**
Total										
Age 40-64	0.0%	0.0%	-19.3%	0.0%	-38.4%	0.0%	-72.3%	0.0%	-12.0%	-87.9%
Age 65+	0.1%	0.1%	-6.4%	0.1%	-19.6%	0.0%	-86.7%	0.0%	4.4%	-89.5%

Ambulatory Care Sensitive Admission Rates for Hypertension (Measure 45)

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4
Ambulatory care sensitive admission rates for hypertension	**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)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**
Total										
Ambulatory care sensitive admission rates for hypertension	0.0%	0.0%	-44.2%	0.0%	-0.6%	0.0%	-31.5%	0.0%	-84.0%	-93.9%

ACS Admission Rates for Pediatric Asthma (Measure 46)

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4
Ambulatory care sensitive (ACS) admission rate: Pediatric Asthma	**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)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**
Total										
Ambulatory care sensitive (ACS) admission rate: Pediatric Asthma	0.0%	0.0%	16.5%	0.0%	-8.8%	0.0%	-73.7%	0.0%	-4.3%	-73.2%

Antidepressant Medication Management (Measure 50)

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4	DY1 to DY4
Antidepressant medication management	**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)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**	**Change (p_4/p_1-1)**
Presbyterian Health Plan											
Effective Acute Phase Treatment	NR	53.9%	N/A	53.4%	-1.1%	51.9%	-2.8%	50.6%	-2.5%	N/A	-6.2%
Effective Continuation Phase Treatment	NR	39.0%	N/A	36.2%	-7.0%	35.6%	-1.9%	34.3%	-3.5%	N/A	-12.0%
Molina Healthcare of New Mexico, Inc.											
Effective Acute Phase Treatment	40.8%	53.5%	31.2%	49.5%	-7.4%	47.2%	-4.8%	45.8%	-3.0%	12.3%	-14.4%
Effective Continuation Phase Treatment	25.1%	38.6%	54.2%	34.7%	-10.2%	32.1%	-7.4%	30.5%	-4.9%	21.9%	-20.9%
Blue Cross and Blue Shield of New Mexico											
Effective Acute Phase Treatment	42.8%	60.0%	40.2%	54.8%	-8.6%	50.6%	-7.7%	47.8%	-5.5%	11.7%	-20.3%
Effective Continuation Phase Treatment	29.9%	47.8%	59.8%	39.4%	-17.5%	34.5%	-12.4%	32.6%	-5.6%	9.0%	-31.8%
United Healthcare of New Mexico, Inc.											
Effective Acute Phase Treatment	51.0%	62.5%	22.6%	56.6%	-9.4%	53.2%	-6.1%	52.3%	-1.6%	2.6%	-16.3%
Effective Continuation Phase Treatment	37.1%	48.3%	30.4%	42.9%	-11.3%	39.0%	-9.2%	37.5%	-3.8%	1.1%	-22.5%
Total											
Effective Acute Phase Treatment	43.2%	55.6%	28.6%	53.1%	-4.4%	50.4%	-5.2%	48.7%	-3.4%	12.6%	-12.5%
Effective Continuation Phase Treatment	28.6%	41.1%	43.9%	37.8%	-8.1%	34.9%	-7.7%	33.2%	-4.8%	16.2%	-19.2%

Percentage of Nursing Facility Residents who Transitioned from a Low Nursing Facility to a High Nursing Facility (Measure 52)

	DY1		DY2		DY3		DY4		DY1 to DY4
Percentage of nursing facility members who transitioned from a low nursing facility (NF) to a high nursing facility (NF)	**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)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_1-1)**
Total									
Number of Low NF	89.7%	N/A	88.8%	-1.0%	95.0%	6.9%	94.6%	-0.5%	5.4%
Number of High NF	10.3%	N/A	11.2%	8.4%	5.0%	-55.1%	5.4%	8.6%	-47.2%

Fall Risk Intervention (Measure 53)

	DY1		DY2		DY3		DY4		DY1 to DY4
Fall Risk Management	**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)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_1-1)**
Total									
Fall Risk Management	16.4%	N/A	21.1%	28.2%	22.8%	8.2%	24.5%	7.6%	49.3%

Percentage of the Population Accessing a Behavioral Health Service that Received a PCP Visit in the Same Year (Measure 54)

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4
Percentage of population accessing a behavioral health service that received a PCP 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)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/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%	12.0%	-1.9%	12.0%	0.5%	-11.8%

Percentage of the Population Accessing an LTSS Service that Received a PCP Visit in the Same Year (Measure 55)

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4
Percentage of LTSS population accessing a PCP visit during the year	**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)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/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%	69.1%	-0.4%	-9.7%

Percentage of the Population Accessing an LTSS Service that also accessed a BH Service in the Same Year (Measure 56)

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4
Percentage of population accessing an LTSS service that also accessed a BH service 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)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**
Total										
Percentage of population accessing an LTSS service that also accessed a BH service in the same year	1.1%	1.1%	-5.4%	1.3%	25.1%	1.4%	4.9%	1.4%	1.1%	25.6%

Percentage of the Population with BH Needs with an ED Visit by Type of ED Visit (Measure 57)

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4
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)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**
Total										
Percentage of population with BH needs with an ED visit by type of ED visit	18.7%	11.0%	-41.0%	7.0%	-36.5%	6.9%	-2.1%	7.3%	5.9%	-61.2%
BH Population with EMTALA ER Visit Type	0.2%	0.1%	-58.9%	0.1%	-13.0%	0.1%	-22.1%	0.8%	1194.0%	260.2%
BH Population with Urgent Care ER Visit Type	0.0%	0.0%	-100.0%	0.0%	N/A	0.0%	-53.4%	0.0%	93.5%	-96.0%
BH Population with Limited or Minor ER Visit Type	0.6%	0.3%	-45.2%	0.4%	15.1%	0.4%	0.7%	0.3%	-18.6%	-48.2%
BH Population with Low to Moderate ER Visit Type	1.8%	0.6%	-66.7%	0.7%	23.5%	0.6%	-14.5%	0.5%	-22.6%	-72.8%
BH Population with Moderate ER Visit Type	6.4%	2.5%	-61.2%	2.2%	-11.3%	2.2%	1.0%	2.3%	4.6%	-63.7%
BH Population with High Severity ER Visit Type	7.0%	2.2%	-68.0%	2.5%	12.6%	2.6%	1.8%	2.6%	-0.4%	-63.4%
BH Population with Life Threatening ER Visit Type	5.4%	2.5%	-54.1%	2.3%	-7.5%	2.2%	-6.0%	2.7%	25.5%	-49.9%
BH Population with Admitted Through ER Visit Type	3.6%	5.1%	44.1%	0.9%	-82.8%	1.0%	11.3%	1.0%	5.1%	-71.0%

Percentage of the Population with LTSS Needs with an ED Visit by Type of ED Visit (Measure 58)

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4
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)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**
Total										
Percentage of population with LTSS needs with an ED visit by type of ED visit	35.7%	37.6%	5.2%	44.2%	17.7%	45.2%	2.1%	45.1%	-0.2%	26.2%
BH Population with EMTALA ER Visit Type	0.3%	0.3%	-14.6%	0.3%	15.0%	0.2%	-24.5%	0.6%	182.2%	109.2%
BH Population with Urgent Care ER Visit Type	0.0%	0.0%	-15.9%	0.0%	-32.5%	0.0%	-28.2%	0.0%	-34.2%	-73.2%
BH Population with Limited or Minor ER Visit Type	1.5%	1.8%	17.0%	2.7%	52.1%	2.7%	0.3%	2.2%	-16.6%	48.8%
BH Population with Low to Moderate ER Visit Type	3.9%	3.7%	-4.6%	4.9%	30.8%	4.6%	-6.3%	3.8%	-17.6%	-3.6%
BH Population with Moderate ER Visit Type	13.3%	13.8%	3.4%	16.1%	16.6%	17.3%	8.0%	17.0%	-2.1%	27.3%
BH Population with High Severity ER Visit Type	15.2%	15.5%	1.8%	19.7%	27.3%	20.9%	6.2%	20.7%	-0.7%	36.7%
BH Population with Life Threatening ER Visit Type	13.2%	14.1%	6.7%	17.2%	22.4%	18.1%	5.1%	19.7%	8.6%	49.0%
BH Population with Admitted Through ER Visit Type	8.7%	12.8%	47.6%	14.5%	13.2%	13.9%	-3.7%	13.3%	-4.4%	53.8%

Percentage of Participants Who Accessed a BH Service that also Accessed HCBS (Measure 60)

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4
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)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**
Total										
Number and percentage of participants who accessed a BH service that also accessed HCBS	0.2%	0.2%	13.2%	0.2%	10.2%	0.2%	-7.5%	0.2%	-2.7%	12.2%

Percentage of the Population Accessing a BH Service that Received an Outpatient Ambulatory Visit in the Same Year (Measure 62)

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4
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)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/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%	15.9%	1.6%	14.4%	-9.5%	-1.0%

Diabetes Screening for Members with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (Measure 63)[193]

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4	DY1 to DY4
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)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**	**Change (p_4/p_1-1)**
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%	79.0%	-0.9%	76.5%	-3.3%	-10.4%	-4.2%
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%	77.3%	-1.5%	77.1%	-0.3%	-3.0%	0.1%
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%	78.0%	2.2%	77.6%	-0.6%	N/A	-2.6%
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%	78.1%	2.2%	76.4%	-2.2%	-5.3%	2.9%
Total											
Diabetes screening for people with schizophrenia or bipolar diso	83.7%	77.6%	-7.2%	77.9%	0.3%	78.1%	0.3%	76.9%	-1.5%	-8.1%	-1.0%

[193] 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)[194]

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4	DY1 to DY4
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)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**	**Change (p_4/p_1-1)**
Presbyterian Health Plan											
Diabetes monitoring for people with diabetes and schizophrenia	76.7%	75.0%	-2.2%	54.9%	-26.8%	63.3%	15.3%	64.0%	1.2%	-16.5%	-14.7%
Molina Healthcare of New Mexico, Inc.											
Diabetes monitoring for people with diabetes and schizophrenia	NR	57.9%	N/A	55.0%	-4.9%	63.7%	15.8%	70.6%	10.8%	N/A	21.9%
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%	46.0%	2.4%	39.6%	-13.8%	N/A	-11.1%
United Healthcare of New Mexico, Inc.											
Diabetes monitoring for people with diabetes and schizophrenia	55.8%	49.8%	-10.9%	47.4%	-4.7%	57.0%	20.1%	62.2%	9.3%	11.5%	25.1%
Total											
Diabetes monitoring for people with diabetes and schizophrenia	62.4%	56.6%	-9.2%	49.9%	-11.8%	57.6%	15.5%	59.2%	2.8%	-5.0%	4.6%

[194] 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.

Asthma Controller Medication Compliance (Measure 80)[195]

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4	DY1 to DY4
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)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**	**Change (p_4/p_1-1)**
Presbyterian Health Plan											
Medication Compliance - 50% (5-11)	47.9%	45.5%	-5.0%	53.4%	17.4%	50.8%	-5.0%	54.0%	6.4%	12.6%	18.6%
Medication Compliance - 75% (5-11)	20.9%	21.3%	2.0%	26.5%	24.1%	26.9%	1.6%	29.8%	10.8%	42.4%	39.7%
Medication Compliance - 50% (12-18)	42.7%	40.6%	-4.9%	48.9%	20.4%	47.4%	-3.0%	50.9%	7.3%	19.2%	25.4%
Medication Compliance - 75% (12-18)	19.5%	18.9%	-3.4%	25.4%	34.8%	26.5%	4.2%	23.6%	-10.7%	21.1%	25.4%
Molina Healthcare of New Mexico, Inc.											
Medication Compliance - 50% (5-11)	44.1%	46.2%	4.8%	46.2%	0.0%	46.5%	0.5%	51.9%	11.6%	17.6%	12.2%
Medication Compliance - 75% (5-11)	22.2%	23.1%	4.2%	21.7%	-6.0%	22.0%	1.1%	25.3%	15.3%	14.1%	9.5%
Medication Compliance - 50% (12-18)	42.7%	44.2%	3.7%	41.5%	-6.1%	44.4%	7.0%	49.5%	11.5%	16.1%	12.0%
Medication Compliance - 75% (12-18)	18.8%	19.1%	2.0%	18.9%	-1.2%	20.7%	9.5%	21.3%	2.9%	13.4%	11.2%
Blue Cross and Blue Shield of New Mexico											
Medication Compliance - 50% (5-11)	43.6%	43.9%	0.6%	45.1%	2.8%	52.3%	15.9%	54.9%	4.9%	25.8%	25.0%
Medication Compliance - 75% (5-11)	18.1%	20.4%	12.8%	22.0%	7.6%	22.8%	3.9%	26.8%	17.8%	48.4%	31.5%
Medication Compliance - 50% (12-18)	43.3%	48.2%	11.3%	35.8%	-25.8%	39.9%	11.6%	39.9%	0.0%	-7.9%	-17.2%
Medication Compliance - 75% (12-18)	16.7%	25.0%	50.0%	15.1%	-39.7%	20.2%	33.9%	16.5%	-18.2%	-0.9%	-33.9%
United Healthcare of New Mexico, Inc.											
Medication Compliance - 50% (5-11)	NR	NR	N/A	31.6%	N/A	48.2%	52.7%	46.8%	-2.9%	N/A	N/A
Medication Compliance - 75% (5-11)	NR	NR	N/A	23.7%	N/A	25.0%	5.6%	21.3%	-14.9%	N/A	N/A
Medication Compliance - 50% (12-18)	NR	NR	N/A	36.7%	N/A	45.5%	24.0%	48.7%	7.2%	N/A	N/A
Medication Compliance - 75% (12-18)	NR	NR	N/A	13.3%	N/A	21.2%	59.1%	25.6%	20.9%	N/A	N/A
Total											
Medication Compliance - 50% (5-11)	46.5%	45.6%	-2.0%	49.1%	7.7%	49.3%	0.3%	53.2%	7.9%	14.3%	16.6%
Medication Compliance - 75% (5-11)	21.1%	21.8%	3.4%	23.9%	9.9%	24.4%	1.7%	27.4%	12.4%	29.9%	25.7%
Medication Compliance - 50% (12-18)	42.7%	42.2%	-1.1%	44.1%	4.4%	45.3%	2.8%	48.9%	7.9%	14.5%	15.8%
Medication Compliance - 75% (12-18)	19.2%	19.4%	1.0%	21.3%	9.9%	23.5%	10.1%	21.9%	-6.6%	14.1%	12.9%

[195] 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.

Treatment Adherence – Schizophrenia (Measure 83)[196]

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4	DY1 to DY4
Treatment adherence - schizophrenia	**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)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**	**Change (p_4/p_1-1)**
Presbyterian Health Plan											
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	24.0%	58.1%	141.9%	56.5%	-2.7%	57.8%	2.4%	57.5%	-0.7%	139.4%	-1.0%
Molina Healthcare of New Mexico, Inc.											
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	NR	58.7%	N/A	52.8%	-10.0%	54.7%	3.5%	51.8%	-5.3%	N/A	-11.8%
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%	47.8%	7.2%	50.8%	6.3%	N/A	-15.3%
United Healthcare of New Mexico, Inc.											
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	50.0%	61.1%	22.2%	54.6%	-10.6%	57.8%	5.9%	57.4%	-0.7%	14.7%	-6.1%
Total											
Adherence to Antipsychotic Medications for Individuals With Schi	34.7%	59.3%	70.8%	52.2%	-12.0%	54.7%	4.9%	54.3%	-0.8%	56.4%	-8.4%

Annual Dental Visit – Adult (Measure 85)

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4	DY1 to DY4
Annual dental visit – adult	**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)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**	**Change (p_4/p_1-1)**
Presbyterian Health Plan											
Annual Dental Visit (19-21 Yrs)	44.2%	39.3%	-11.1%	41.2%	4.8%	42.9%	4.2%	45.8%	6.5%	3.4%	16.3%
Molina Healthcare of New Mexico, Inc.											
Annual Dental Visit (19-21 Yrs)	45.9%	35.5%	-22.8%	43.6%	22.9%	43.8%	0.6%	51.2%	16.7%	11.4%	44.3%
Blue Cross and Blue Shield of New Mexico											
Annual Dental Visit (19-21 Yrs)	41.0%	29.6%	-27.8%	37.1%	25.2%	37.8%	1.9%	39.2%	3.8%	-4.4%	32.5%
United Healthcare of New Mexico, Inc.											
Annual Dental Visit (19-21 Yrs)	NR	25.9%	N/A	28.6%	10.4%	32.3%	13.2%	38.8%	20.0%	N/A	50.0%
Total											
Annual Dental Visit (19-21 Yrs)	44.4%	34.9%	-21.5%	40.4%	15.9%	41.8%	3.4%	46.2%	10.6%	4.0%	32.5%

[196] 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)[197]

	Baseline	DY1		DY2		DY3		DY4		Baseline to DY4	DY1 to DY4
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)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Rate, p_4**	**Change (p_4/p_3-1)**	**Change (p_4/p_0-1)**	**Change (p_4/p_1-1)**
Presbyterian Health Plan											
Annual Dental Visit (2-3 Yrs)	55.6%	54.4%	-2.3%	52.9%	-2.6%	57.0%	7.7%	58.9%	3.3%	5.8%	8.3%
Annual Dental Visit (4-6 Yrs)	75.0%	73.2%	-2.5%	71.7%	-2.1%	74.4%	3.8%	76.0%	2.2%	1.3%	3.9%
Annual Dental Visit (7-10 Yrs)	79.1%	76.7%	-3.0%	75.0%	-2.3%	77.1%	2.9%	79.4%	2.9%	0.3%	3.4%
Annual Dental Visit (11-14 Yrs)	74.1%	72.6%	-2.0%	70.6%	-2.8%	74.2%	5.1%	75.3%	1.5%	1.6%	3.7%
Annual Dental Visit (15-18 Yrs)	64.3%	61.9%	-3.7%	61.5%	-0.7%	63.9%	4.0%	65.4%	2.2%	1.7%	5.6%
Molina Healthcare of New Mexico, Inc.											
Annual Dental Visit (2-3 Yrs)	55.6%	51.1%	-8.1%	57.8%	13.2%	58.2%	0.6%	61.9%	6.4%	11.4%	21.2%
Annual Dental Visit (4-6 Yrs)	74.3%	67.8%	-8.6%	74.8%	10.2%	75.0%	0.4%	77.6%	3.4%	4.5%	14.4%
Annual Dental Visit (7-10 Yrs)	78.9%	71.0%	-10.0%	78.3%	10.2%	78.4%	0.2%	80.5%	2.7%	2.1%	13.4%
Annual Dental Visit (11-14 Yrs)	74.2%	66.2%	-10.9%	74.7%	12.9%	75.6%	1.2%	78.0%	3.2%	5.0%	17.8%
Annual Dental Visit (15-18 Yrs)	64.0%	57.1%	-10.9%	65.1%	14.1%	65.9%	1.2%	69.4%	5.3%	8.4%	21.6%
Blue Cross and Blue Shield of New Mexico											
Annual Dental Visit (2-3 Yrs)	56.5%	47.8%	-15.4%	48.8%	2.0%	51.1%	4.7%	55.6%	8.7%	-1.7%	16.1%
Annual Dental Visit (4-6 Yrs)	73.3%	63.3%	-13.7%	65.2%	3.1%	67.2%	3.0%	70.5%	4.9%	-3.9%	11.4%
Annual Dental Visit (7-10 Yrs)	75.5%	66.9%	-11.3%	68.1%	1.7%	70.7%	3.9%	72.4%	2.4%	-4.1%	8.2%
Annual Dental Visit (11-14 Yrs)	68.1%	61.4%	-9.9%	63.5%	3.4%	66.8%	5.3%	68.0%	1.8%	-0.1%	10.8%
Annual Dental Visit (15-18 Yrs)	59.1%	51.4%	-13.0%	55.2%	7.3%	56.4%	2.2%	59.0%	4.5%	-0.3%	14.7%
United Healthcare of New Mexico, Inc.											
Annual Dental Visit (2-3 Yrs)	NR	36.4%	N/A	41.8%	14.6%	46.1%	10.3%	54.2%	17.7%	N/A	48.8%
Annual Dental Visit (4-6 Yrs)	NR	51.3%	N/A	58.4%	13.9%	59.5%	1.8%	66.8%	12.3%	N/A	30.2%
Annual Dental Visit (7-10 Yrs)	NR	54.8%	N/A	59.2%	8.0%	63.2%	6.8%	69.7%	10.3%	N/A	27.2%
Annual Dental Visit (11-14 Yrs)	NR	48.8%	N/A	54.6%	12.0%	59.6%	9.1%	65.8%	10.5%	N/A	35.0%
Annual Dental Visit (15-18 Yrs)	NR	39.9%	N/A	42.3%	6.2%	48.0%	13.4%	56.0%	16.7%	N/A	40.5%
Total											
Annual Dental Visit (2-3 Yrs)	55.7%	51.6%	-7.5%	53.5%	3.8%	55.4%	3.5%	58.7%	6.0%	5.4%	13.9%
Annual Dental Visit (4-6 Yrs)	74.6%	69.3%	-7.1%	71.1%	2.7%	72.5%	1.9%	75.1%	3.5%	0.6%	8.3%
Annual Dental Visit (7-10 Yrs)	78.7%	72.9%	-7.4%	74.6%	2.3%	76.0%	1.9%	78.2%	2.9%	-0.7%	7.3%
Annual Dental Visit (11-14 Yrs)	73.6%	68.4%	-7.1%	70.4%	3.0%	73.0%	3.6%	74.8%	2.5%	1.6%	9.3%
Annual Dental Visit (15-18 Yrs)	63.8%	58.5%	-8.3%	61.0%	4.4%	62.8%	2.9%	65.4%	4.1%	2.6%	11.9%

[197] 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.

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%