Deloitte.

Centennial Care:

Evaluation Interim Report

Demonstration Years 1 – 2 and Preliminary Demonstration Year 3:

January 2014 – December 2016

October 2017

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Executive Summary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Program Background

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

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

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

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

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

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

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

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

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

[5] STC 122: Interim Evaluation Report.

Evaluation Plan Design

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

Program Goals and Hypotheses

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

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

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

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

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

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

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

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

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

Approach

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

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

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

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

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

Data Utilized

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

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

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

Evaluation Limitations

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

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

Additional limitations include:

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

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

Evaluation Analysis Results

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

Hypothesis 1

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

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

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

Research Question 1.A

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

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

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

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

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

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

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

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

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

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

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

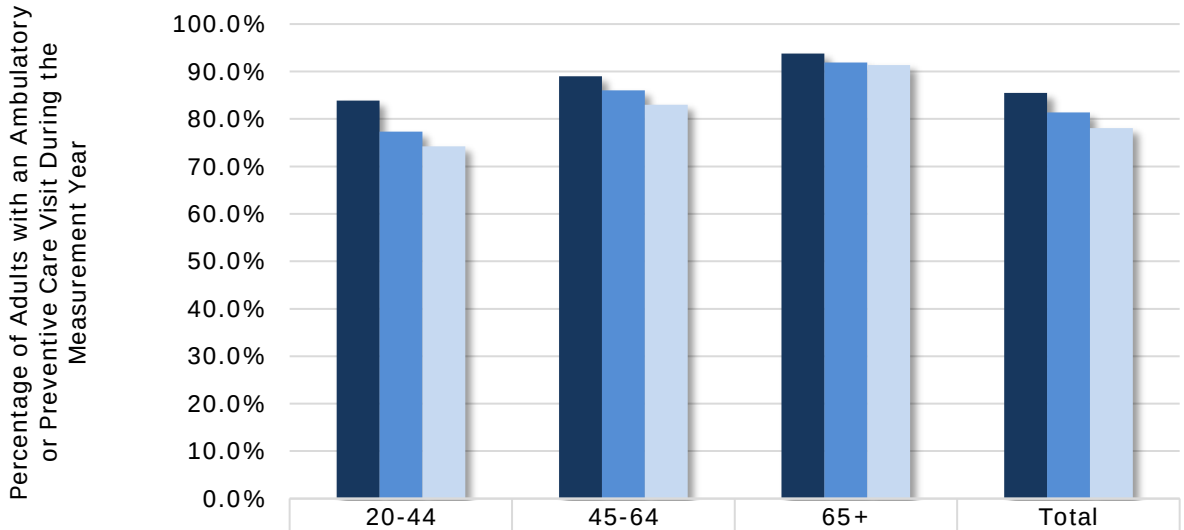
Exhibit 1 presents rates for the 2013 baseline, DY1, and DY2 for the measure Access to Ambulatory/Preventive Care. As illustrated, the rates for each of the three age cohorts as well as the aggregate rate experienced a decrease from DY1 to DY2. The largest decrease among the age cohorts was experienced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

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

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

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

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



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

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

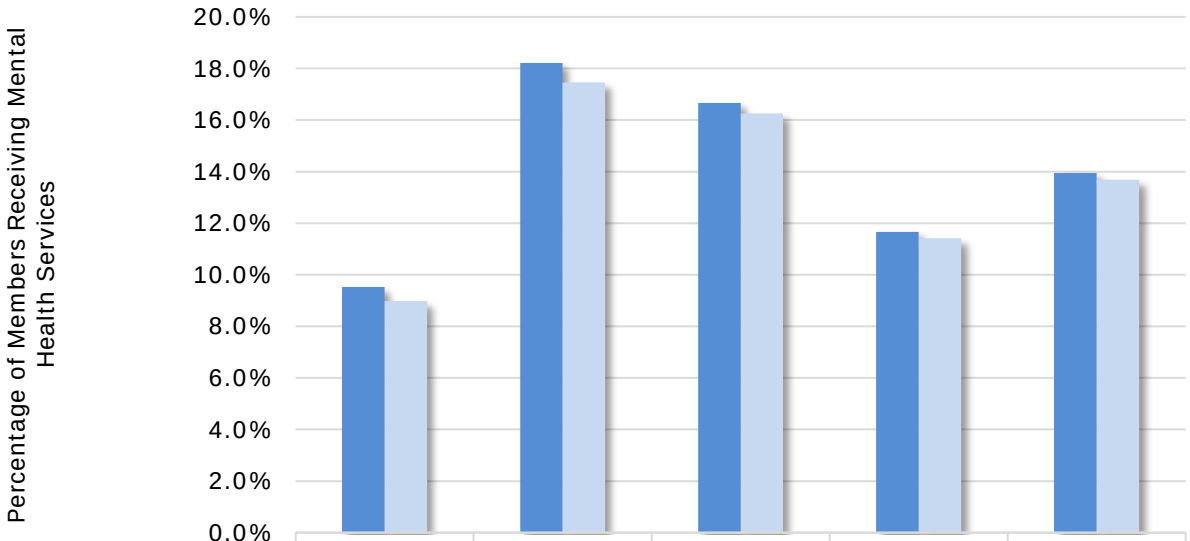
Measure 2 – Mental health services utilization (Members receiving any mental health service with mental health as the principal diagnosis).

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

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

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

Exhibit 2 – Mental Health Services Utilization Aggregate[8]



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

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

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

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

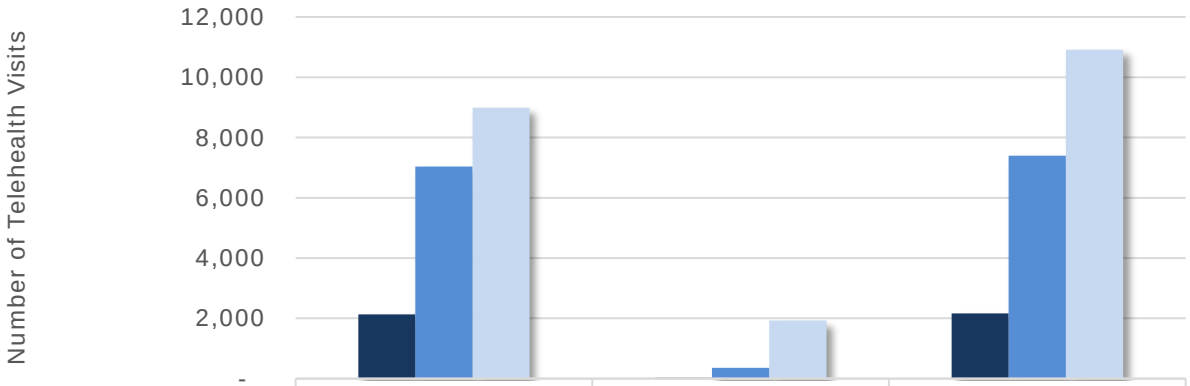
Aggregate utilization (both PH and BH) increased across all MCOs. UHC experienced the greatest increase (81.2%), while BCBS, MHC, and PHP increased by 72.5%, 48.7%, and 25.2%, respectively.

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

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

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

Exhibit 3 – Telemedicine Utilization[9]



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

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

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

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

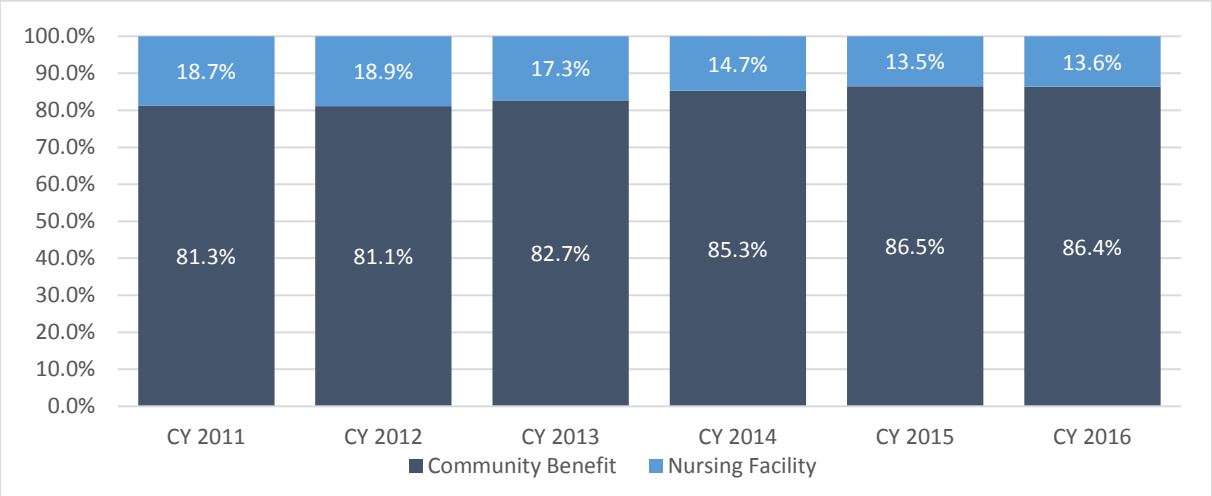
The number of unique members receiving HCBS increased from 24,015 to 29,799 (a 24.1% increase) from DY1 to DY3[10].

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

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

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

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

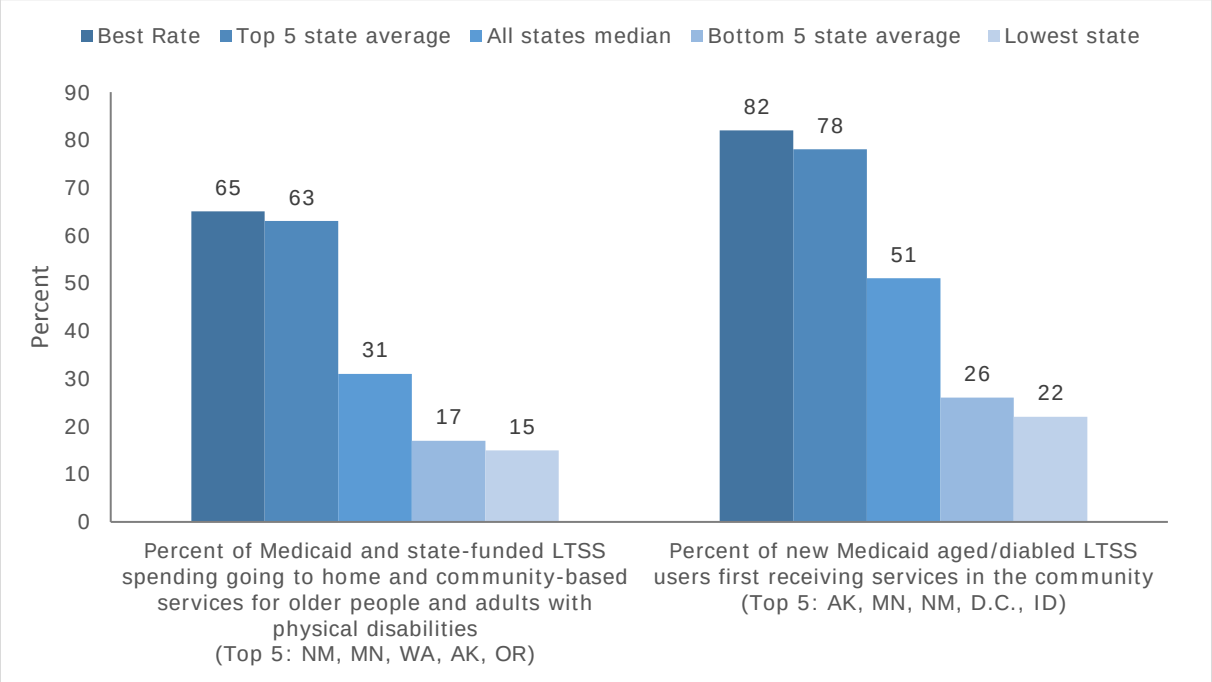


In the AARP's annual report for 2014, *State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities and Family Caregivers*, New Mexico ranks first in the nation for

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

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

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



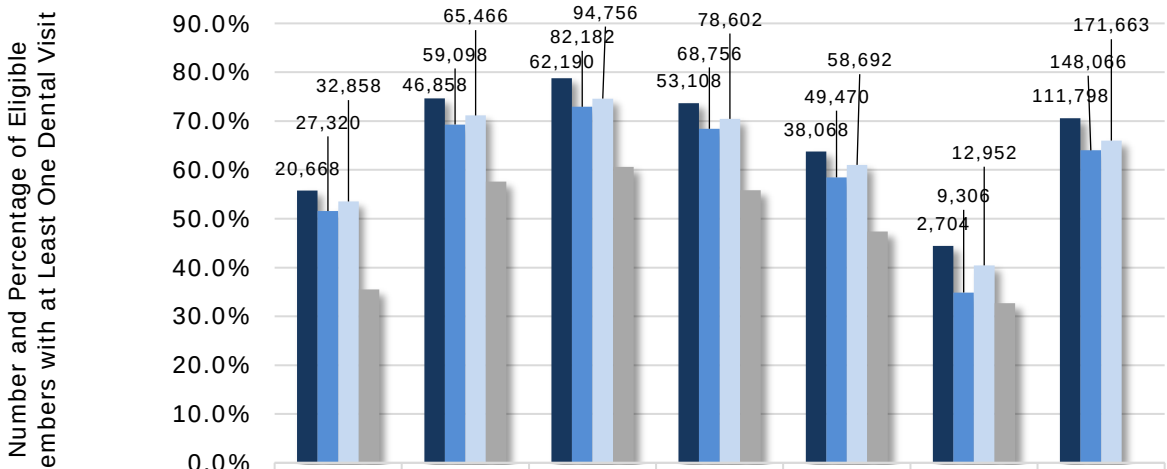
Measure 6 – Number and percentage of people with annual dental visit.

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

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

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

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



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

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

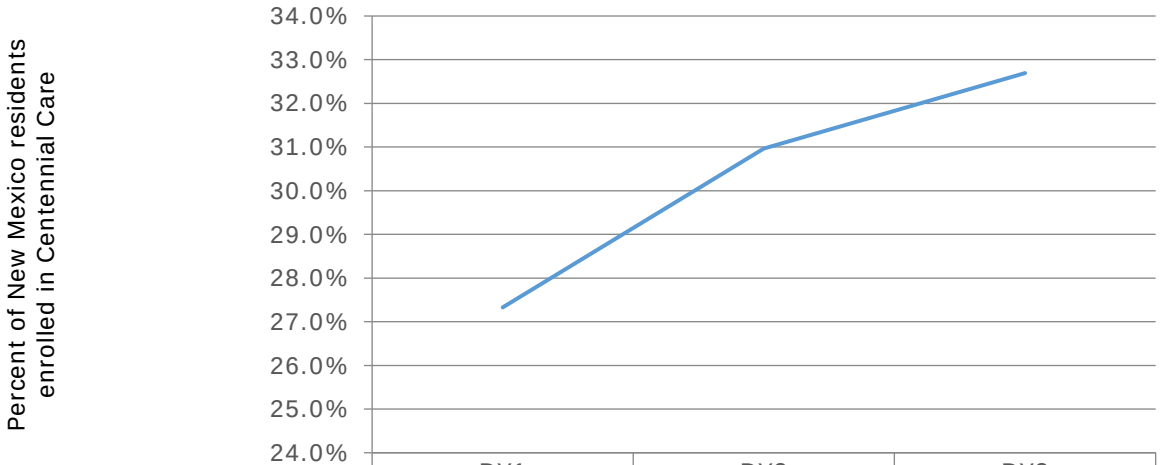
Measure 7 – Enrollment in Centennial Care as a percentage of state population.

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

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

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

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



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

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

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

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

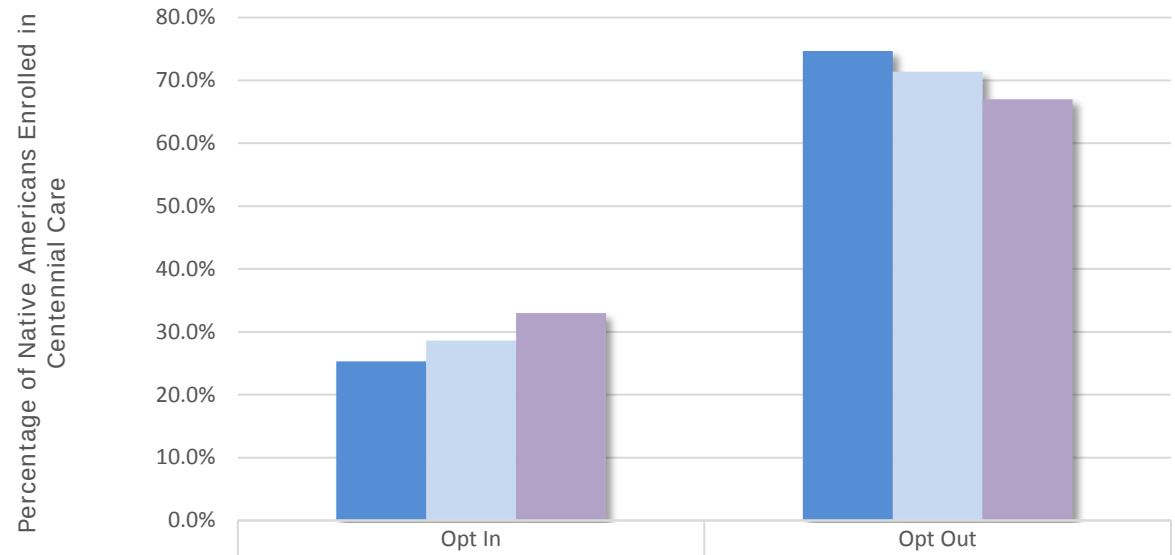
As illustrated, Native Americans' preference for Centennial Care grew as the opt-out rate declined from 71.4% to 67.0%, while the rate at which Native Americans opted-in increased from 28.6% to 33.0% from DY2 to DY3.

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

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

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

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



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

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

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

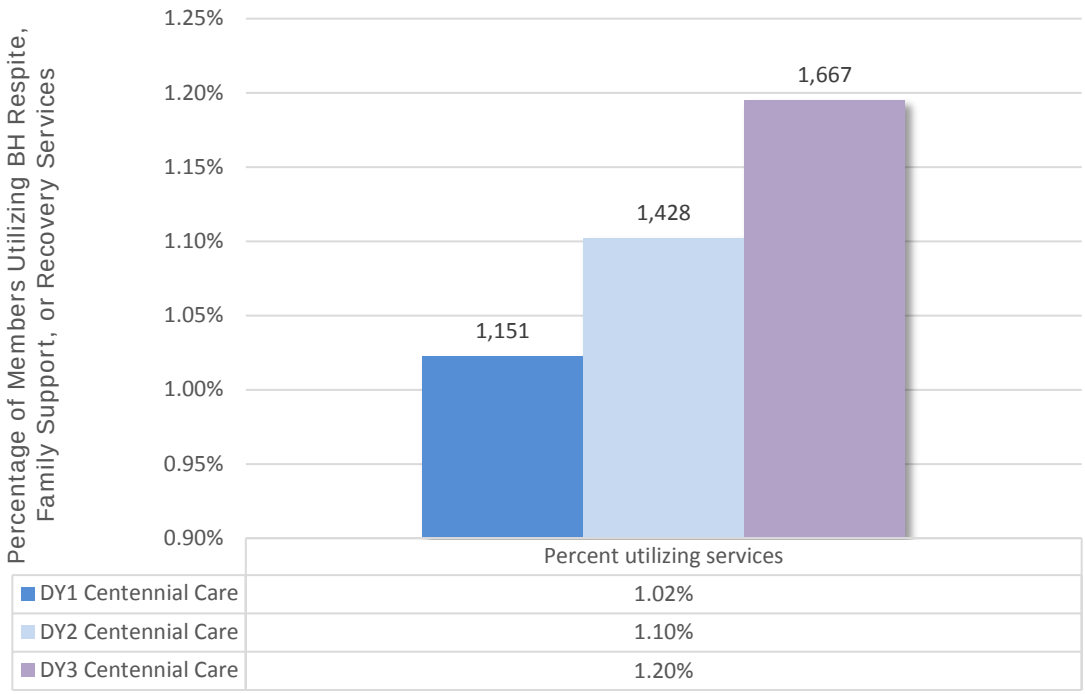
Exhibit 10 presents rates for DY1, DY2, and DY3 for the utilization of new BH services. The three new services were not fully operational in DY1 and DY2 and there are several considerations with respect to the results:

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

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

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

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



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

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

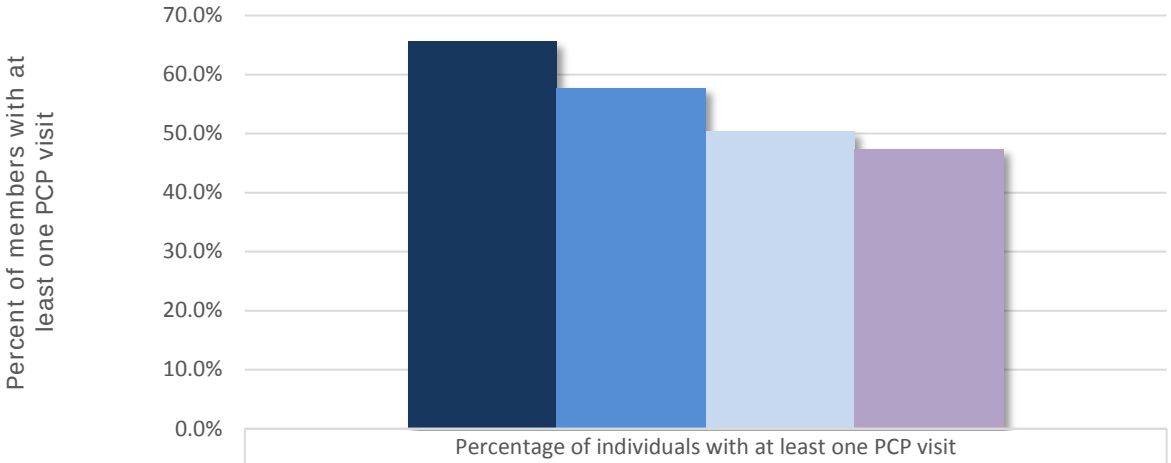
Measure 11 – Number and percentage of unduplicated participants with at least one PCP visit.

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

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

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

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



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

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

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

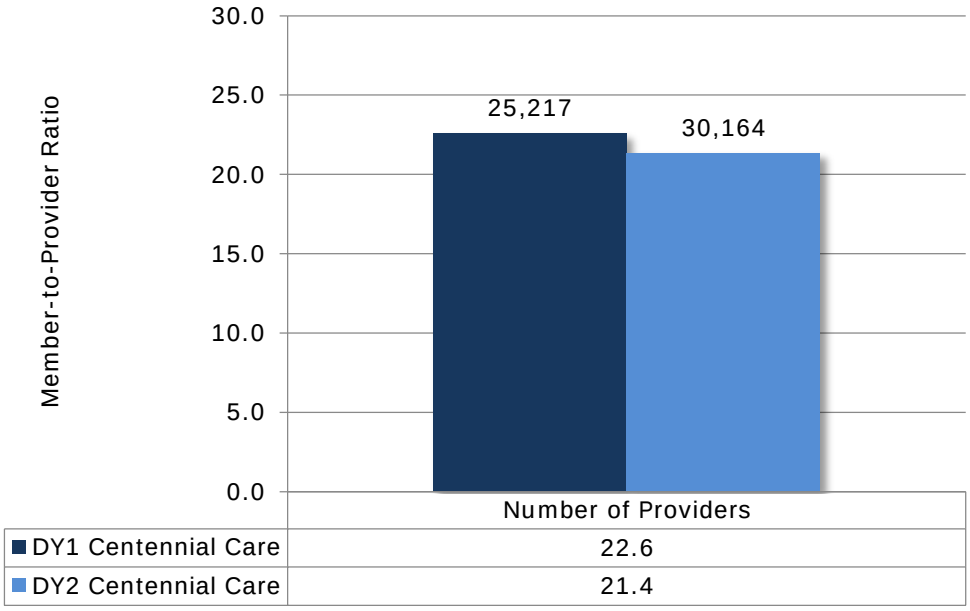
Exhibit 12 presents results for DY1 and DY2 for the number and ratio of providers to members. This measure was not reported previously due to the data source and reporting methodology undergoing refinements.

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

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

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

Exhibit 12 – Number/Ratio of Participating Provider to Members



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

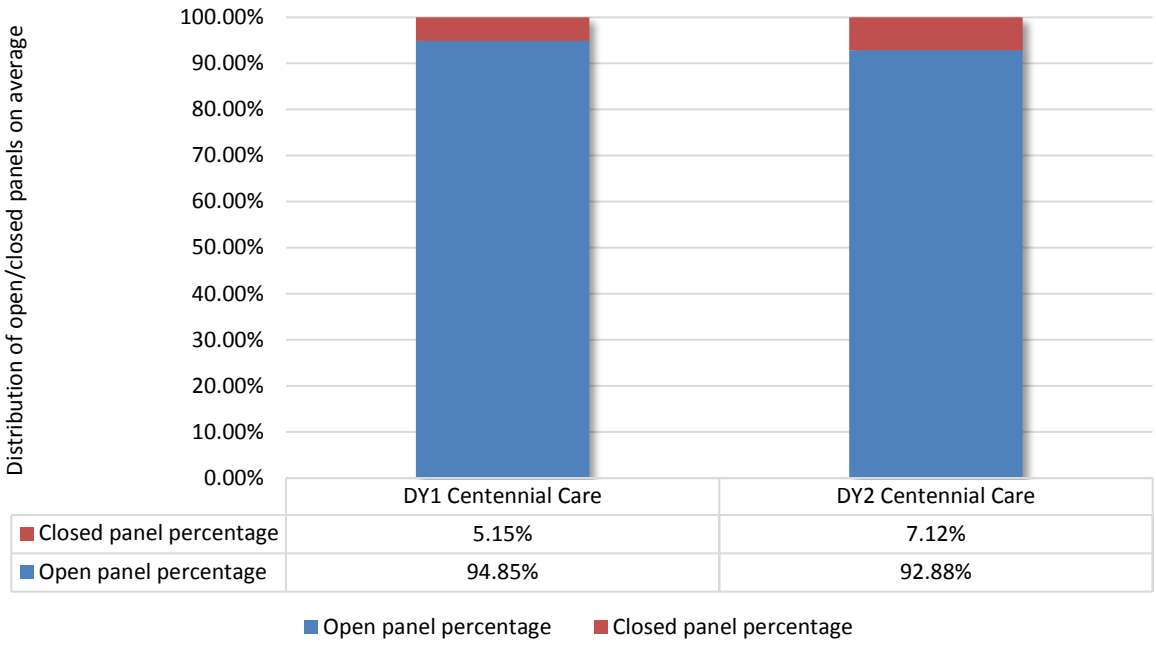
Exhibit 13 presents rates for DY1 and DY2 for PCPs with Open Panels. As illustrated, the percentage of open panels declined by 2.1% from DY1 to DY2. Conversely, the number of closed panels increased by 38.1% in this same interval. Despite these changes, the overall percentage of open panels remained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

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

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

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

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



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

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

Research Question 1.B

Is access to care timely under Centennial Care?

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

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

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

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

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

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

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

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

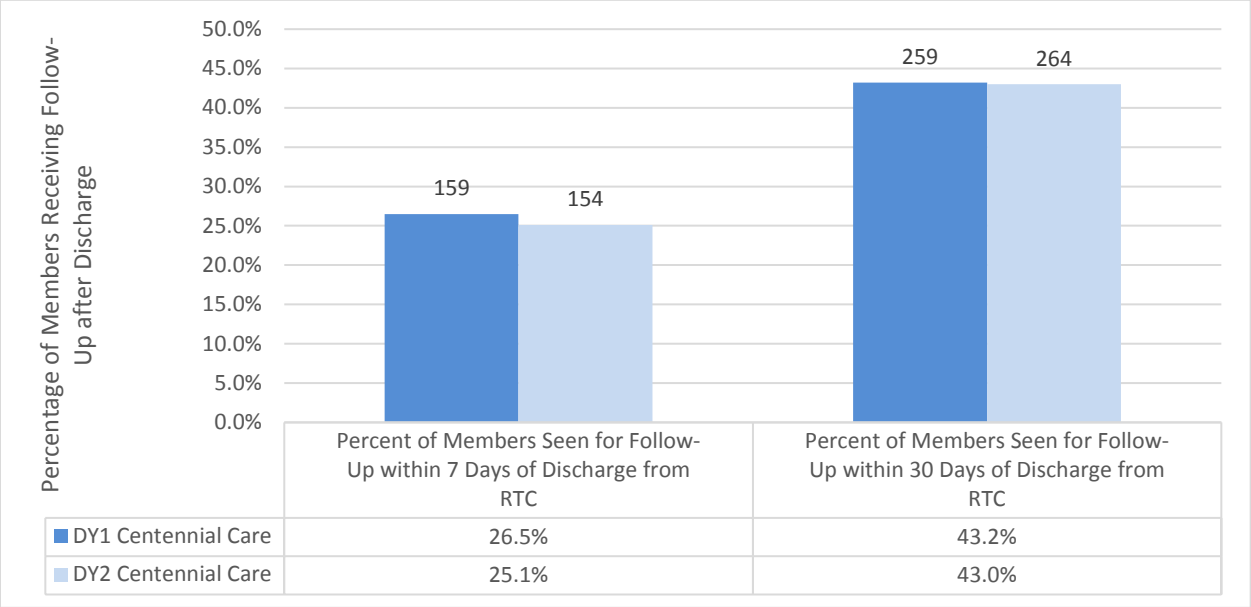
Exhibit 14 presents results for DY1 and DY2 for the Number and Percentage of Substance Use Disorder Participants with Follow-up 7 and 30 Days after leaving a RTC. RTCs serve the youth population under age 21 who are enrolled in Centennial Care.

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

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

A national comparison could not be identified for this measure.

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



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

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

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

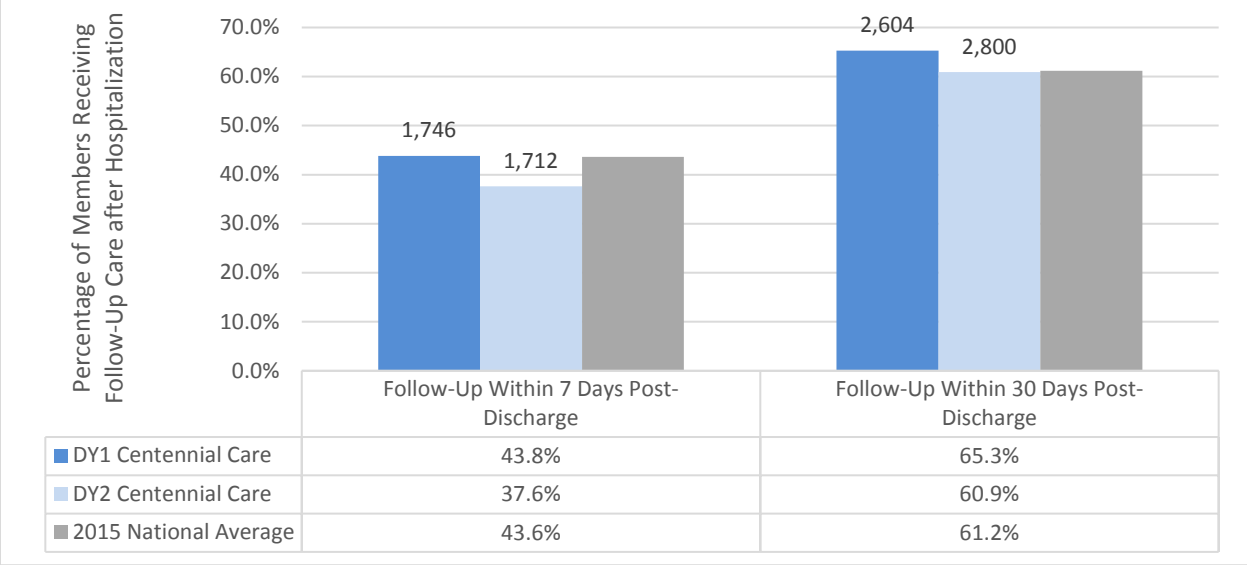
Exhibit 15 presents results for the percentage of members who were discharged after a hospitalization for mental illness and seen for follow-up care within 7 days and 30 days for DY1, DY2, and 2015 HEDIS Medicaid national averages.

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

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

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

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



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

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

Measure 16 – Childhood immunization status.

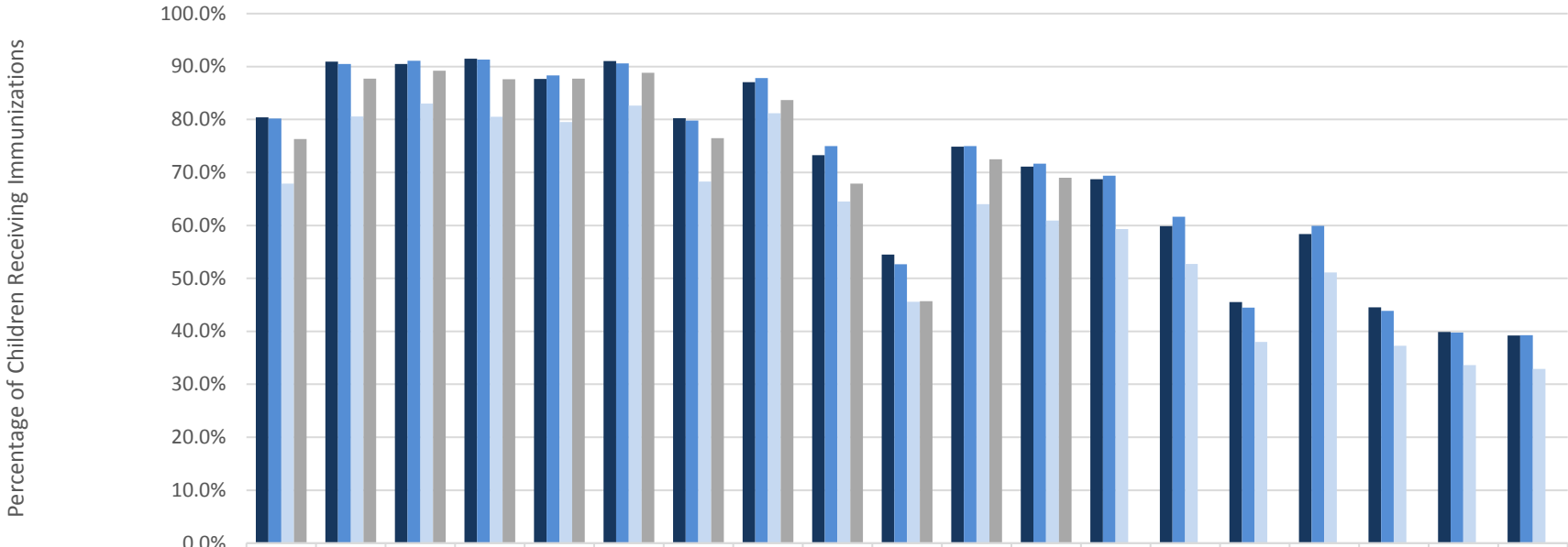
Exhibit 16 presents rates for the 2013 baseline, DY1, DY2, and 2015 HEDIS Medicaid national averages for the 19 subcomponent rates and the aggregate rate for the Childhood Immunization Status measure. The evaluation provides results for 10 vaccines and 9 separate combination rates for three out of the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

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

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

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

Exhibit 16 – Childhood Immunization Status[21]



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

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

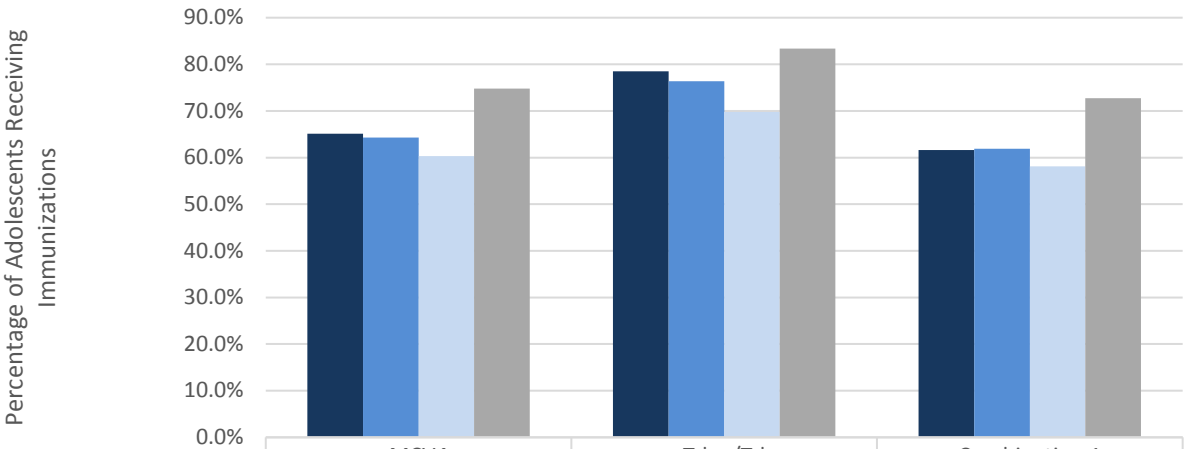
Measure 17 – Immunizations for Adolescents.

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

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

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

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

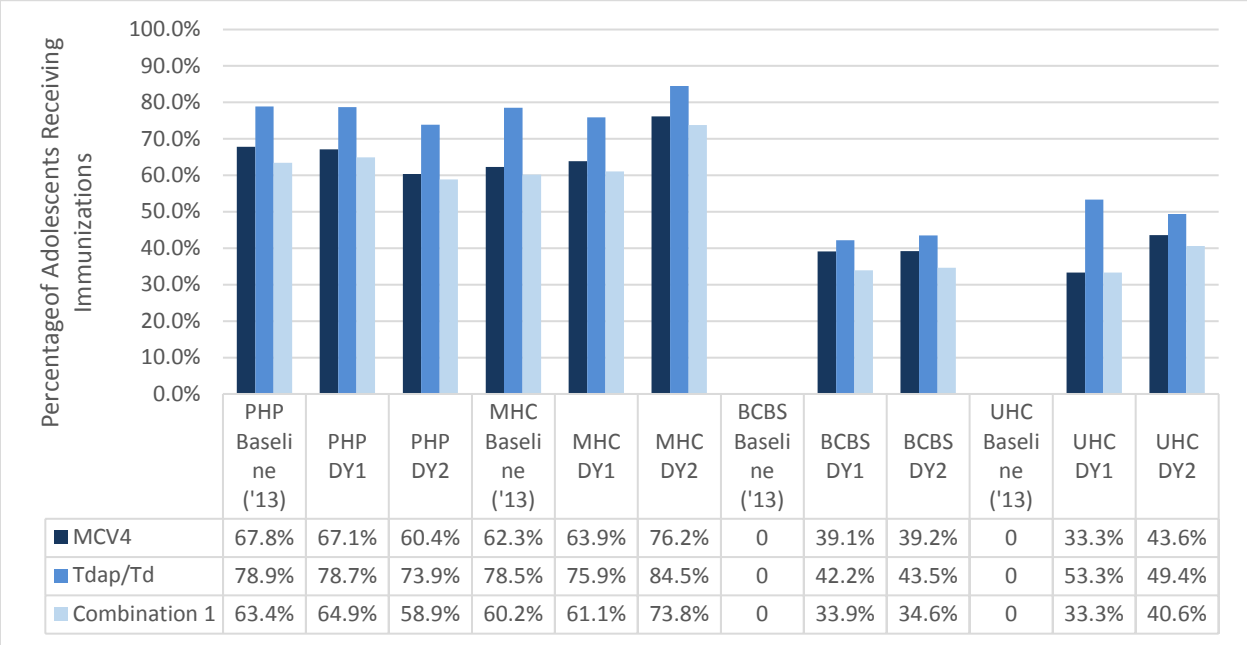


	MCV4	Tdap/Td	Combination 1
2013 Baseline	65.1%	78.5%	61.6%
DY1 Centennial Care	64.3%	76.4%	61.9%
DY2 Centennial Care	60.3%	69.8%	58.1%
2015 National Average	74.8%	83.4%	72.7%

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

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

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



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

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

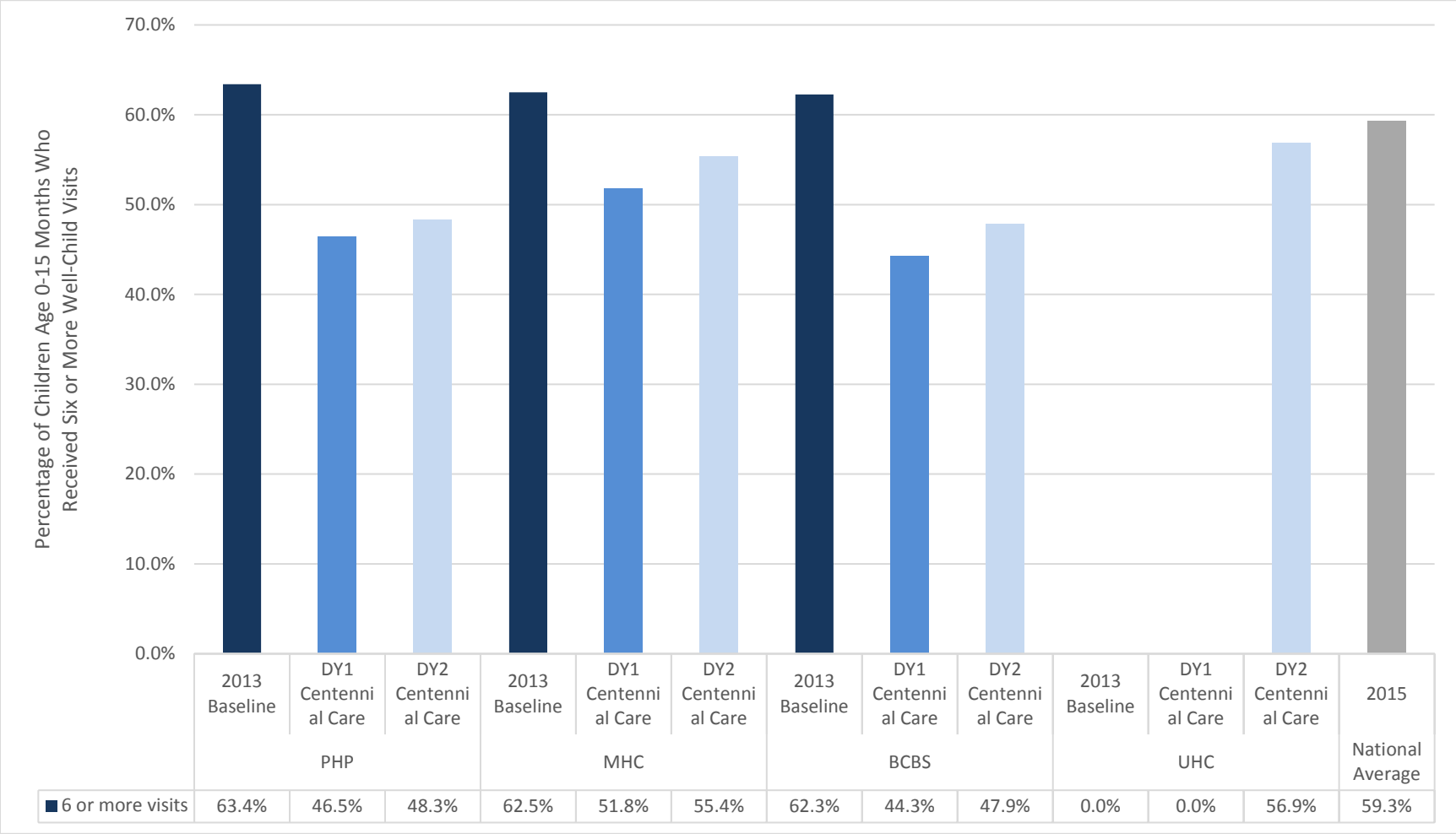
Measure 18 – Well-Child visits in first 15 months of life.

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

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

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

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



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

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

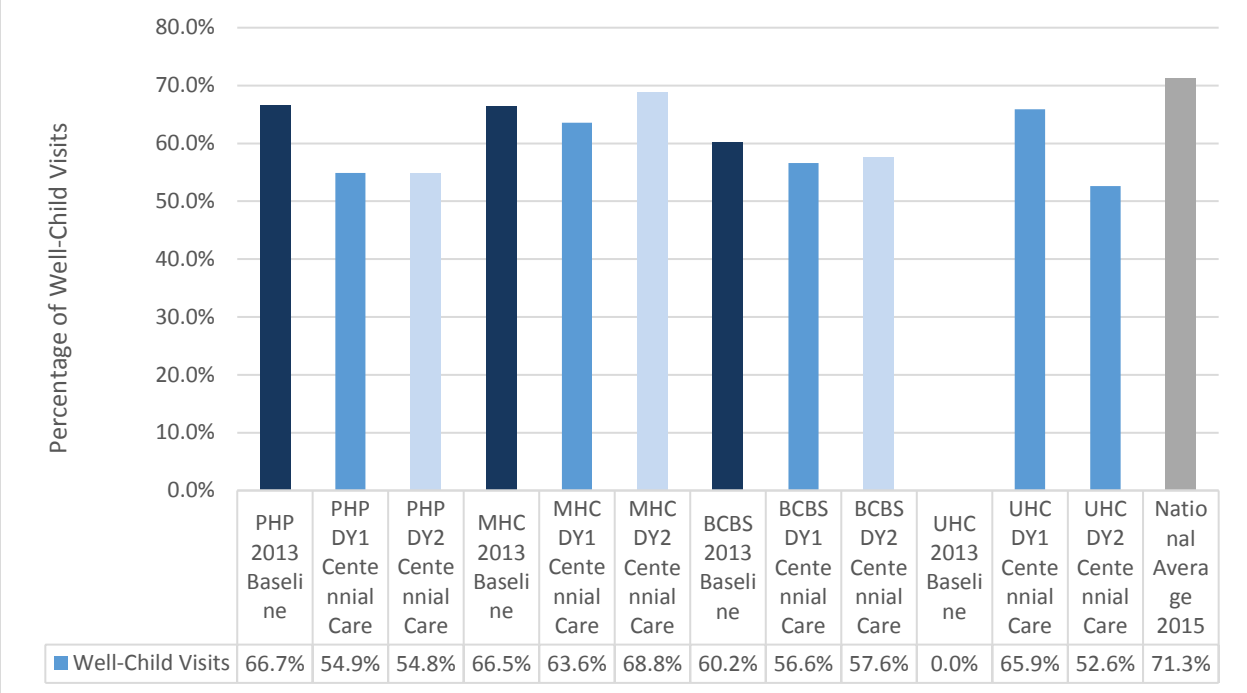
Measure 19 – Well-Child visits in third, fourth, fifth and sixth years of life.

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

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

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

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



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

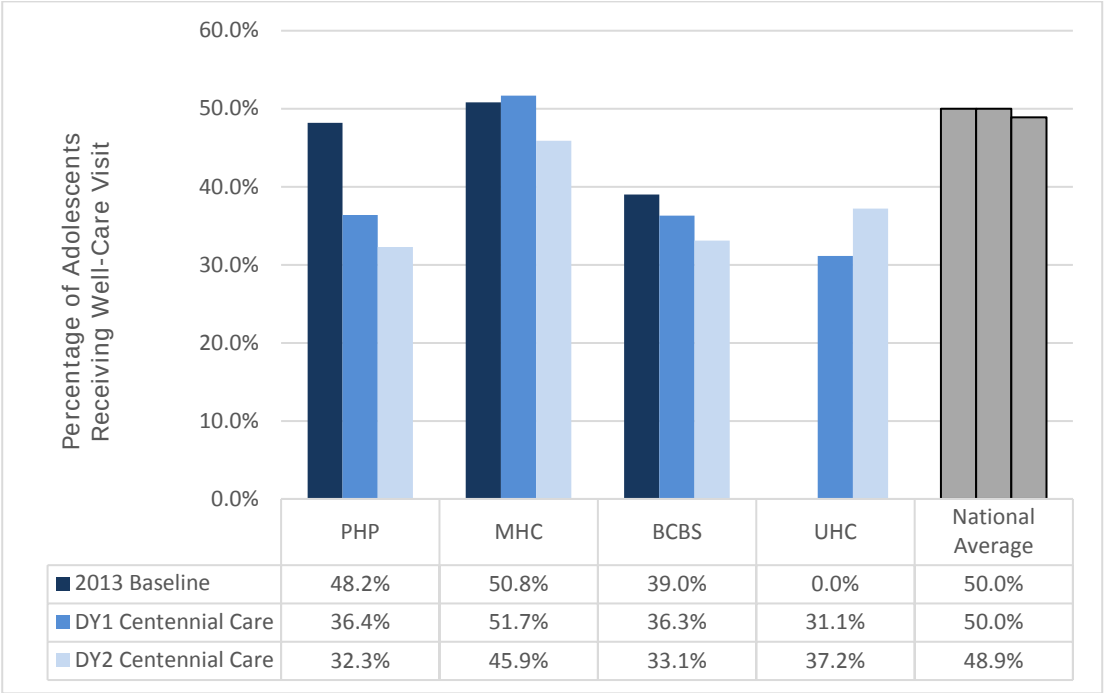
[26] Source: MCO annual HEDIS reports for 2013 – 2015. UHC reported "Not Reportable" (NR) in the baseline. PHP and BCBS reported rates under the Administrative methodology in DY1 and DY2, while MHC report rates under the Hybrid methodology in DY1 and DY2. UHC reported under the Hybrid methodology in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

Measure 20 – Adolescent well care visits.

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

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

Exhibit 20 – Adolescent Well Care Visits[27]



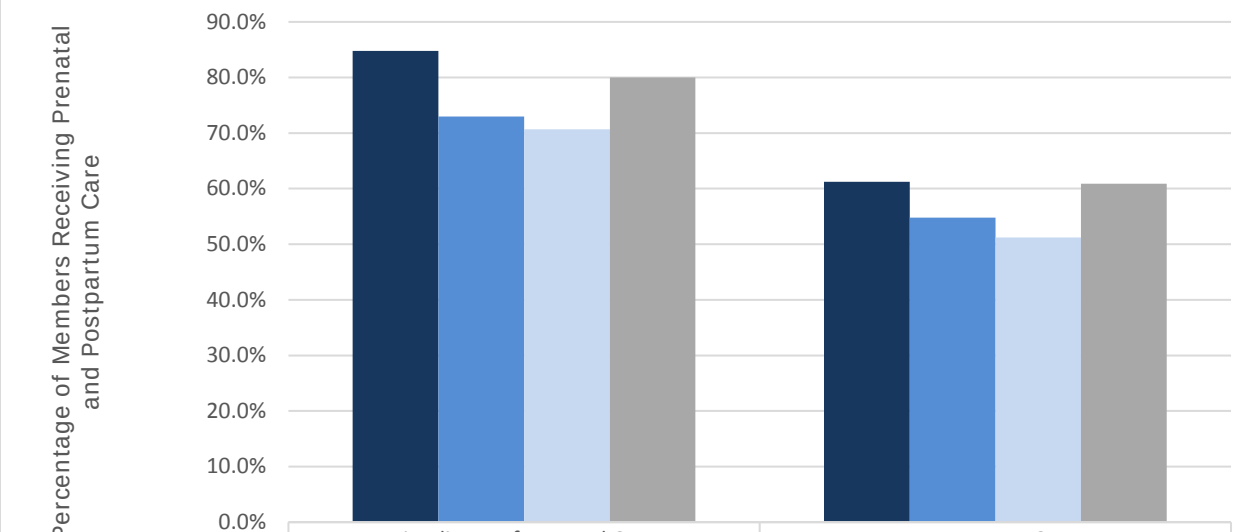
	PHP	MHC	BCBS	UHC	National Average
2013 Baseline	48.2%	50.8%	39.0%	0.0%	50.0%
DY1 Centennial Care	36.4%	51.7%	36.3%	31.1%	50.0%
DY2 Centennial Care	32.3%	45.9%	33.1%	37.2%	48.9%

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

Measure 21 – Prenatal and postpartum care.

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

Exhibit 21 – Prenatal and Postpartum Care[28]



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

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

Measure 22 – Frequency of ongoing prenatal care.

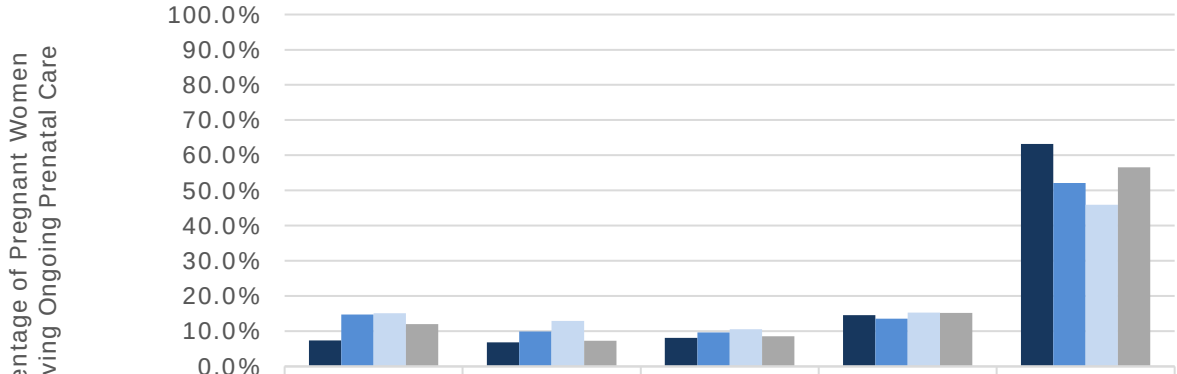
Exhibit 22 presents rates for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national averages for the Frequency of Ongoing Prenatal Care measure. This measure parses the number of expected prenatal care visits into a distribution, represented by the different subcomponents. The number of expected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

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

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

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

Exhibit 22 – Frequency of Ongoing Prenatal Care[29]



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

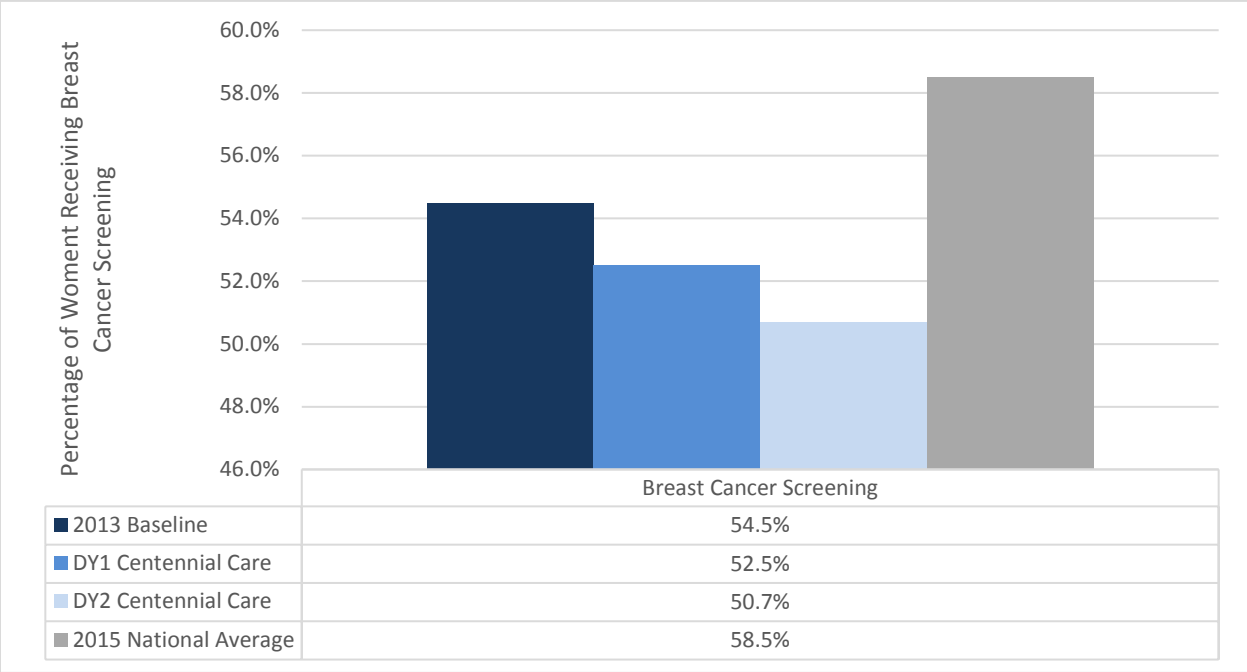
[29] Source: MCO annual HEDIS reports for 2013 – 2015.

Measure 23 – Breast cancer screening for women.

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

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

Exhibit 23 – Breast Cancer Screening for Women[30]



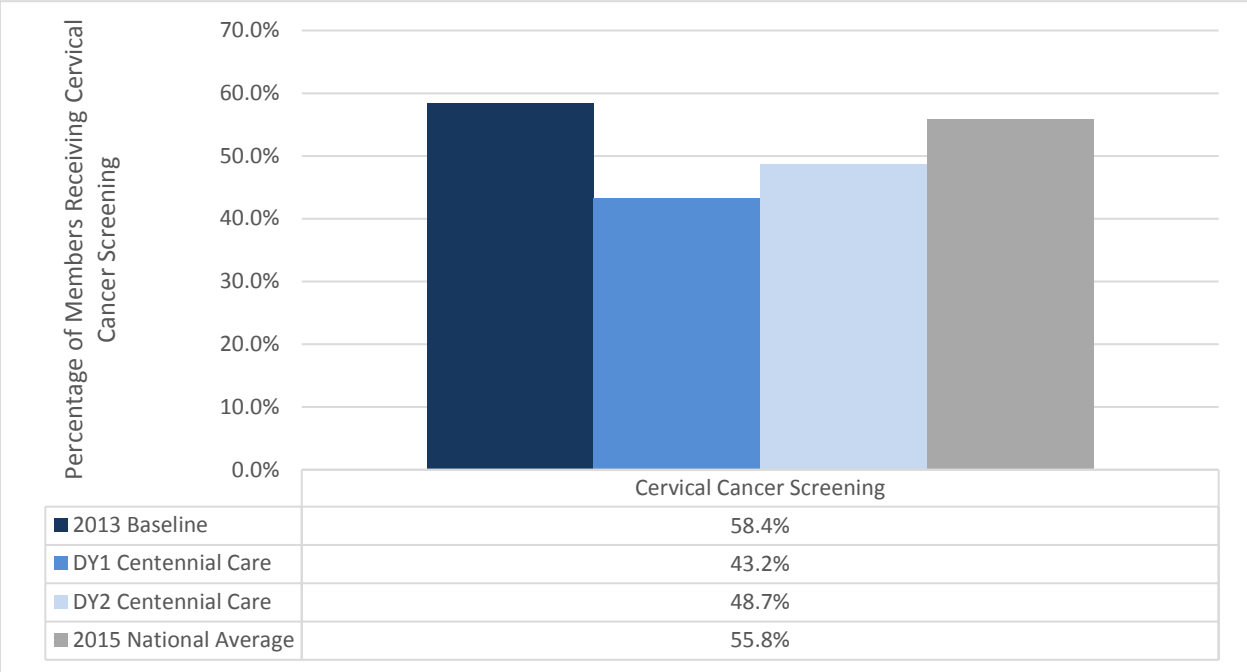
	Breast Cancer Screening
2013 Baseline	54.5%
DY1 Centennial Care	52.5%
DY2 Centennial Care	50.7%
2015 National Average	58.5%

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

Measure 24 – Cervical cancer screening for women.

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

Exhibit 24 – Cervical Cancer Screening for Women[31]



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

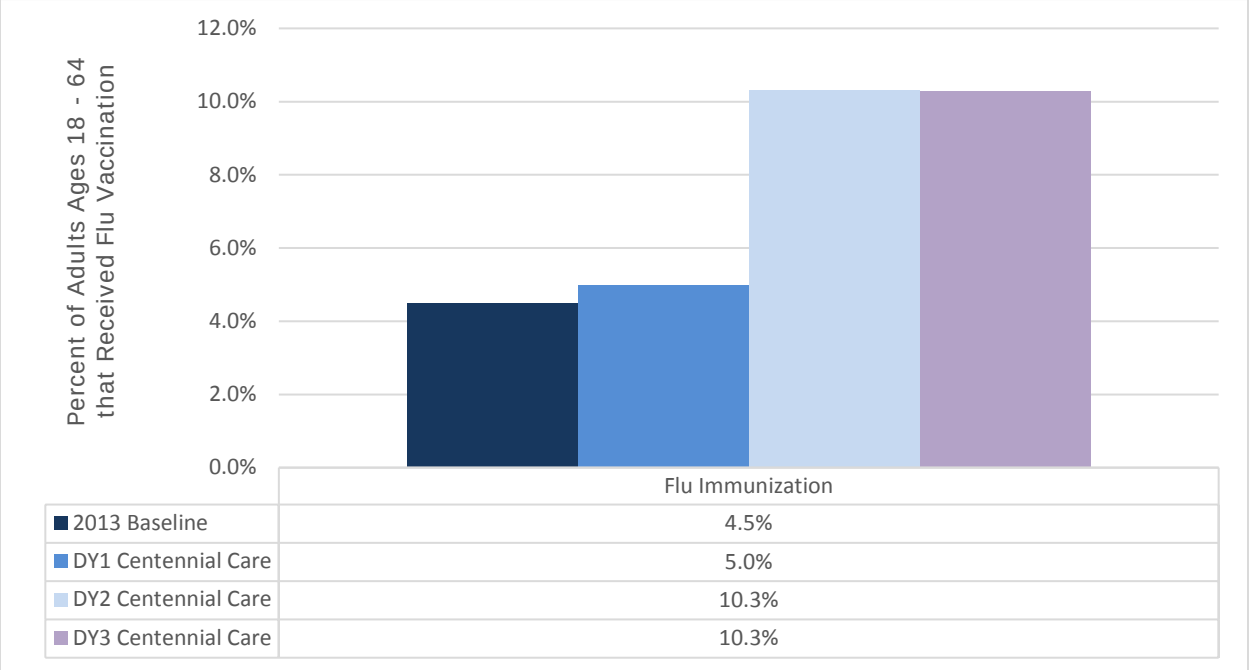
[31] Source: MCO annual HEDIS reports for 2013 – 2015.

Measure 25 – Flu vaccinations for adults.

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

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

Exhibit 25 – Flu Vaccinations for Adults[32]



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

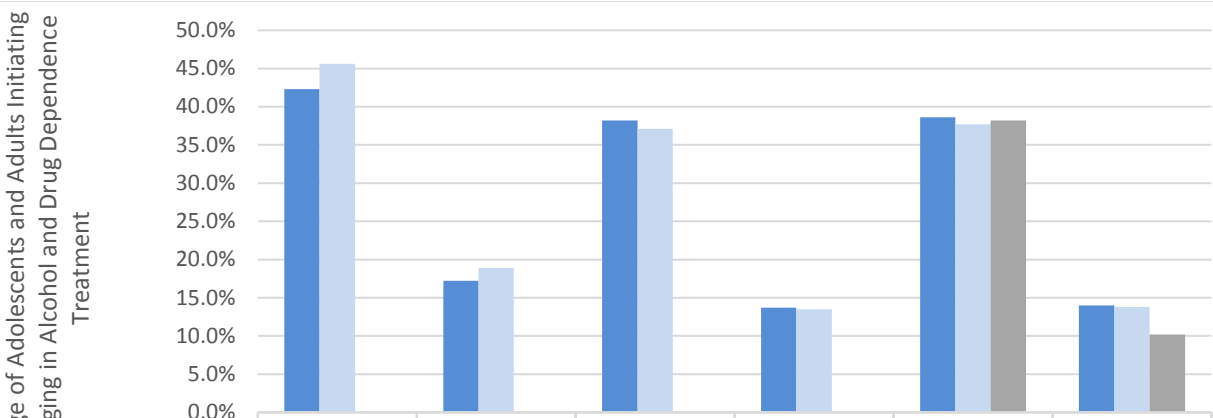
[32] Source: Flu vaccination MMIS reports for 2013 – 2016.

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

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

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

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

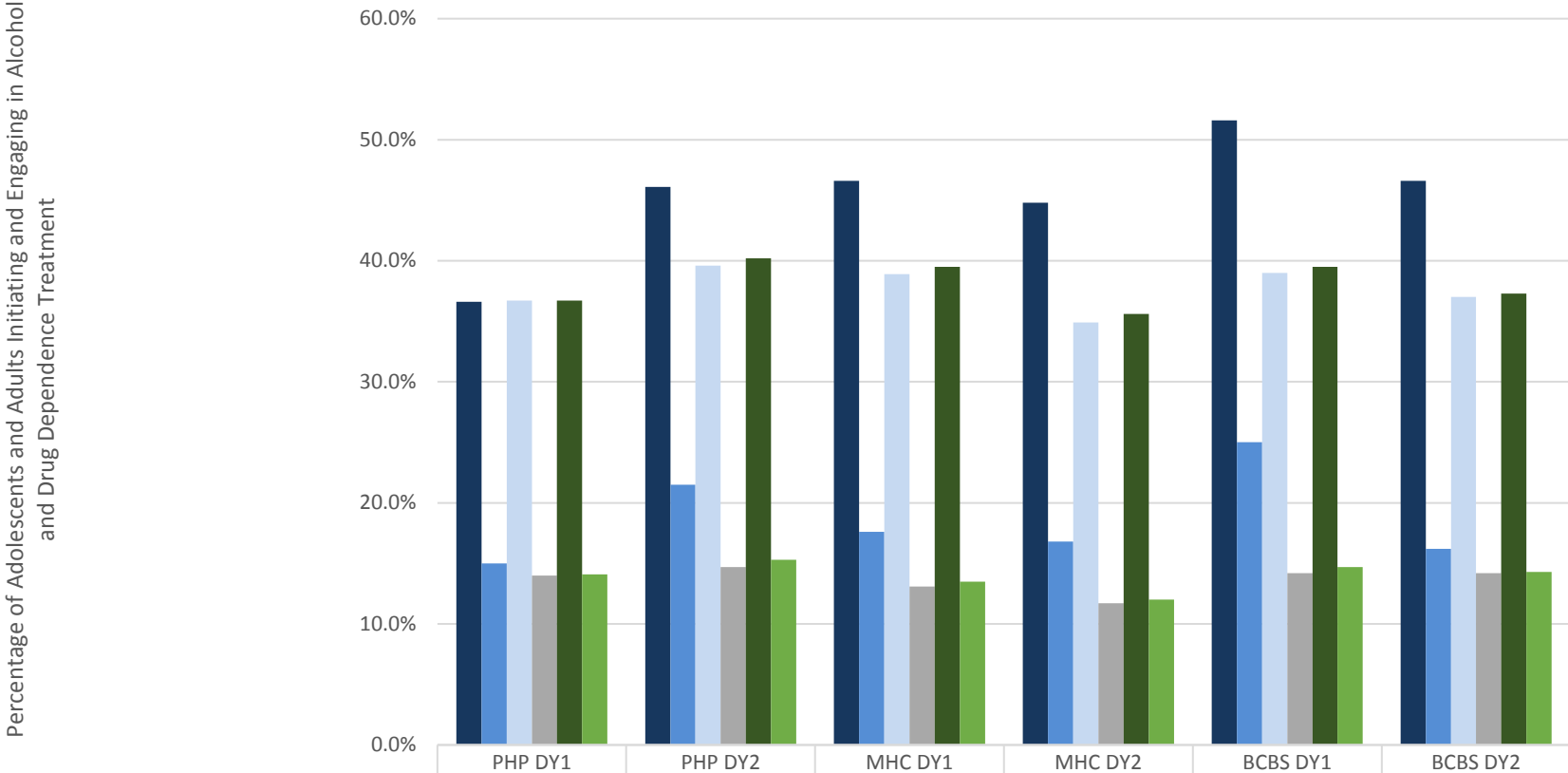


	13-17 years		18+ years		Total	
	Initiation of AOD Treatment	Engagement of AOD Treatment	Initiation of AOD Treatment	Engagement of AOD Treatment	Initiation of AOD Treatment	Engagement of AOD Treatment
DY1 Centennial Care	42.3%	17.2%	38.2%	13.7%	38.6%	14.0%
DY2 Centennial Care	45.6%	18.9%	37.1%	13.5%	37.7%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

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

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

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



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

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

Measure 27 – Geographic access measures.

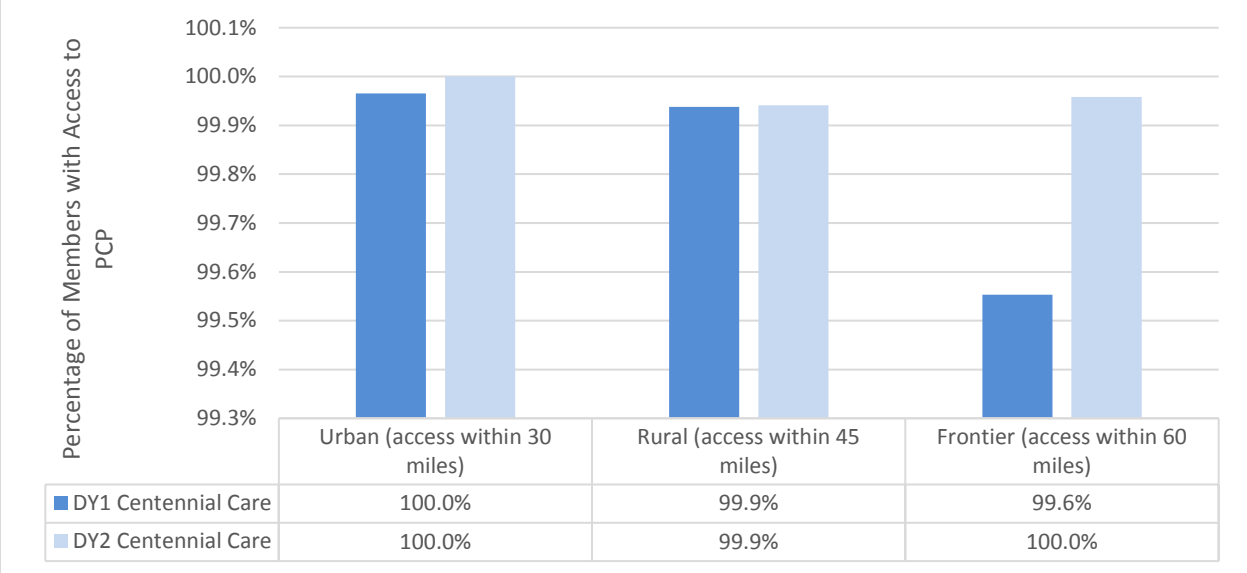
Geographic Access Measures is a general measure developed by HSD as a way to evaluate access to primary and specialty care for Centennial Care members across the State of New Mexico. Monitoring the networks of providers contracted by HSD assures its Medicaid beneficiaries are within a reasonable driving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

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

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

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

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

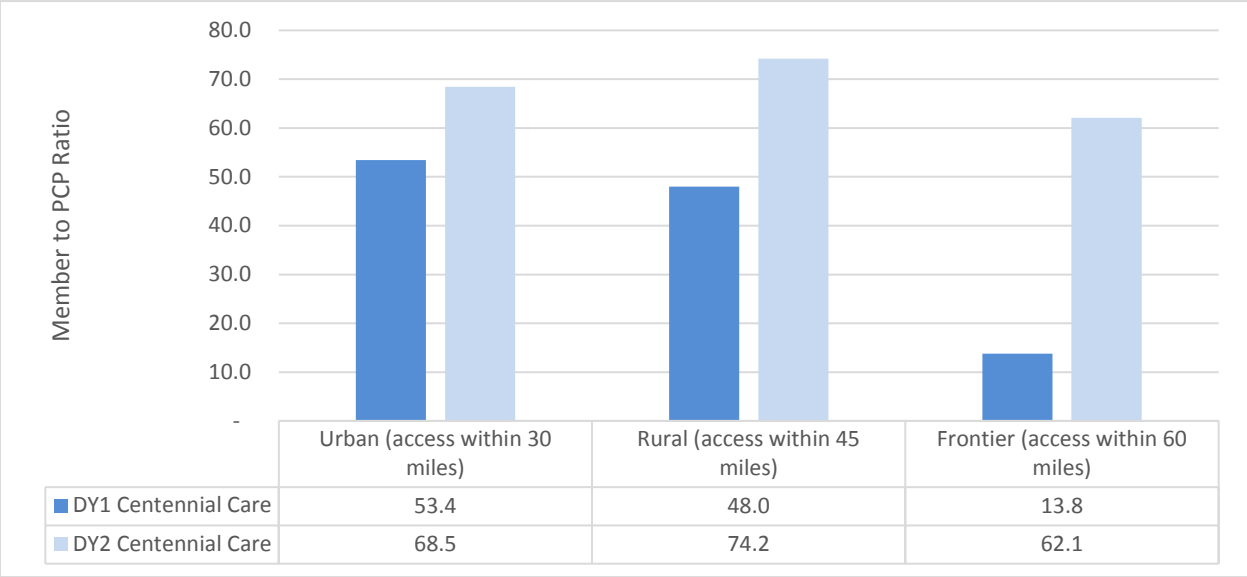


	Urban (access within 30 miles)	Rural (access within 45 miles)	Frontier (access within 60 miles)
DY1 Centennial Care	100.0%	99.9%	99.6%
DY2 Centennial Care	100.0%	99.9%	100.0%

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

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

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



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

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

Research Question 1.C

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

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

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

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

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

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

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

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

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

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

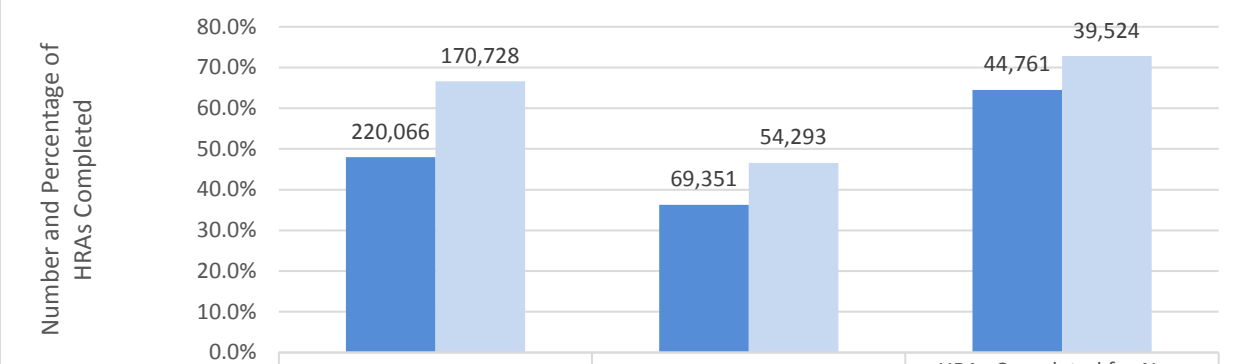
Exhibit 28 presents the results for DY1 and DY2 for the three subcomponents reflecting completed HRAs for transition and new members. Results of the number and percentage of HRAs completed within contract timeframes for transition and new members, as well as HRAs completed within 30 days of enrollment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

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

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

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

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



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

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

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

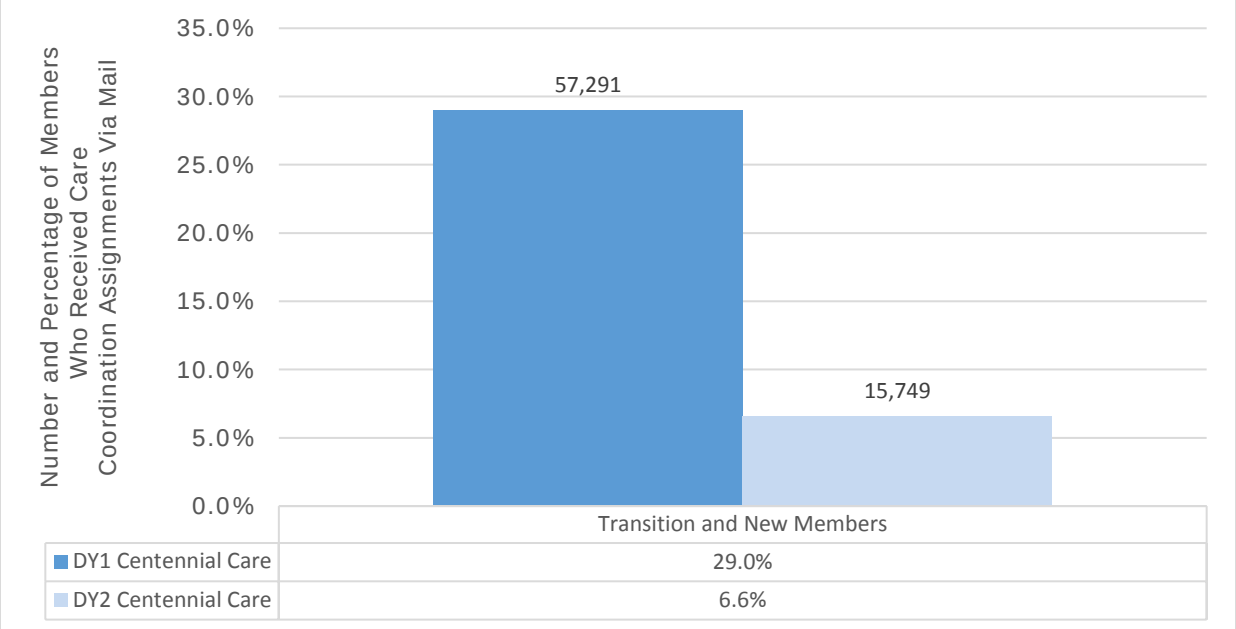
Exhibit 29 below presents results for DY1 and DY2 for the Number of Medicaid Members who were Provided Care Coordination Level Assignments within 10 Calendar Days of an HRA. This definition is being used by HSD as an alternative for "the number and percentage of participants who received a care coordination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

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

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

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

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



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

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

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

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

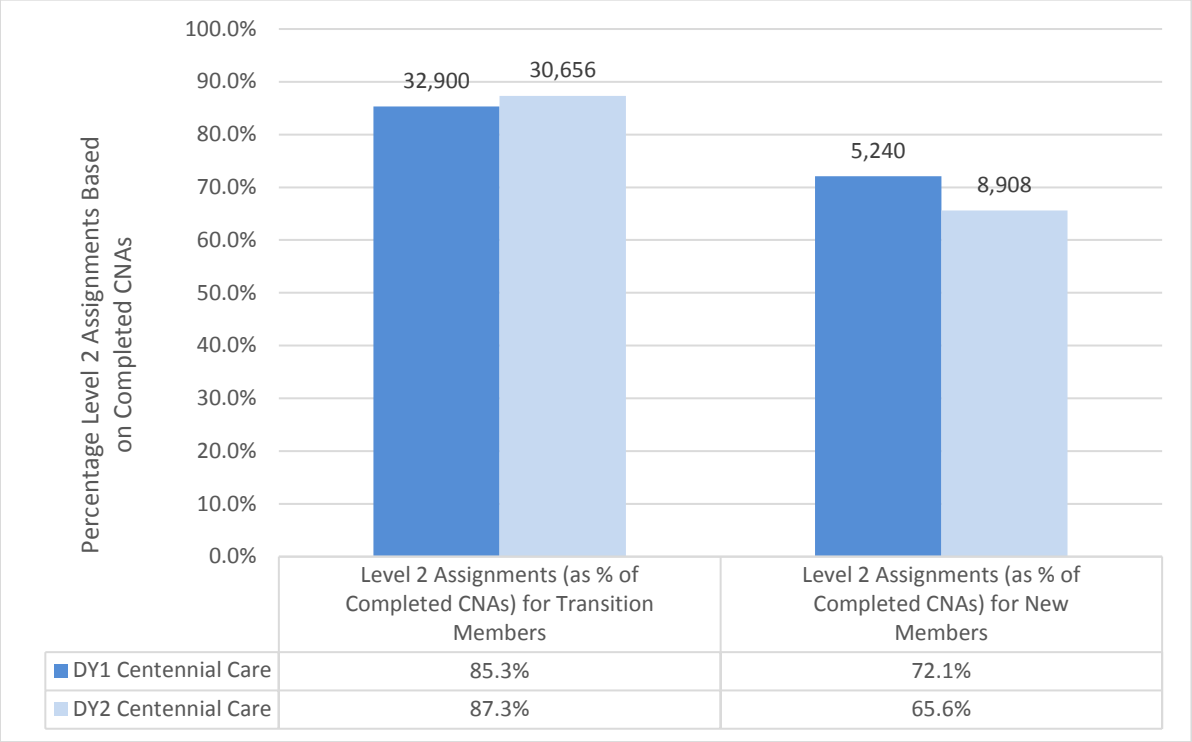
As Exhibit 30 illustrates, the percentage of transition members reported by three of the four MCOs that were assigned to Level 2 from DY1 to DY2 remained relatively consistent, staying between 85.3% and 87.3%. By comparison, a lower percentage of new Medicaid members were assigned to Level 2 and the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

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

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

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

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



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

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

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

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

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

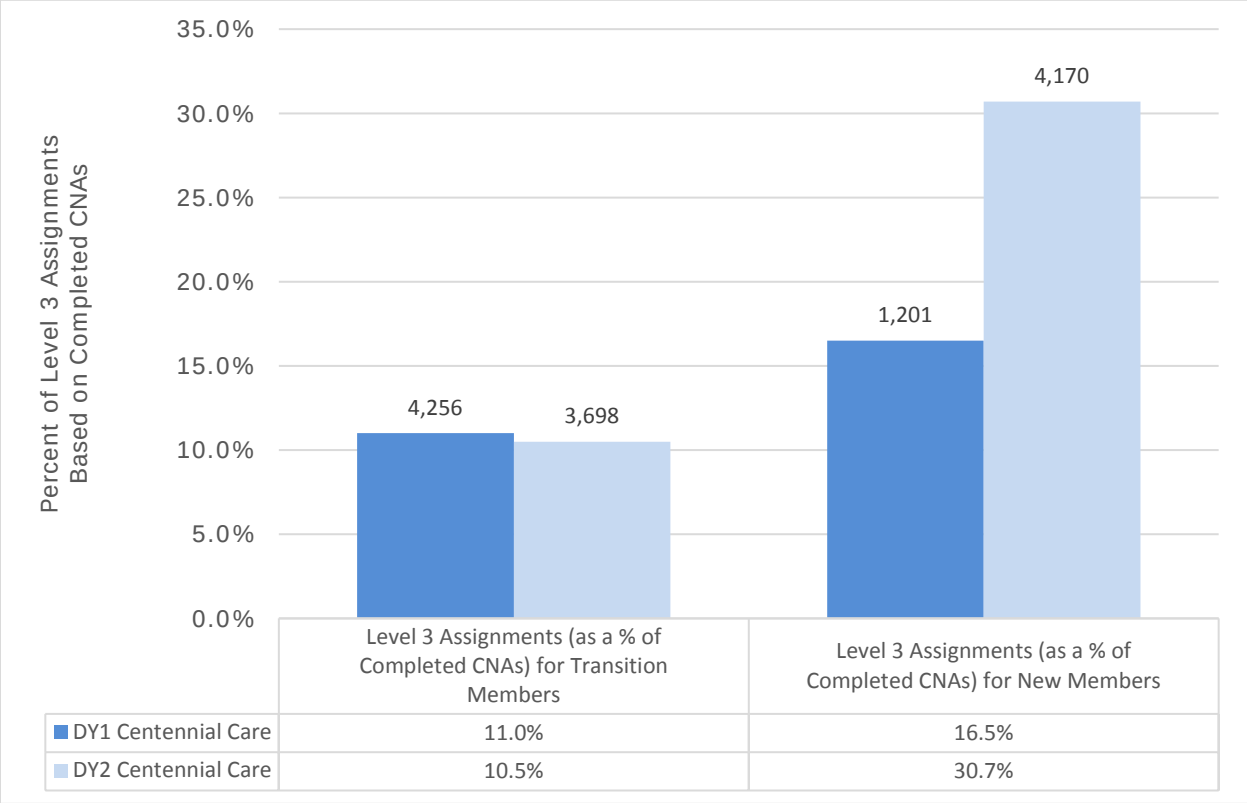
As Exhibit 31 illustrates, the percentage of new members who were assigned to Level 3 was greater than the percentage of transition members assigned to Level 3. The percentage of transition members assigned to Level 3 remained fairly level from DY1 to DY2 (11.0% and 10.5% respectively). Conversely, the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

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

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

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

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



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

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

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

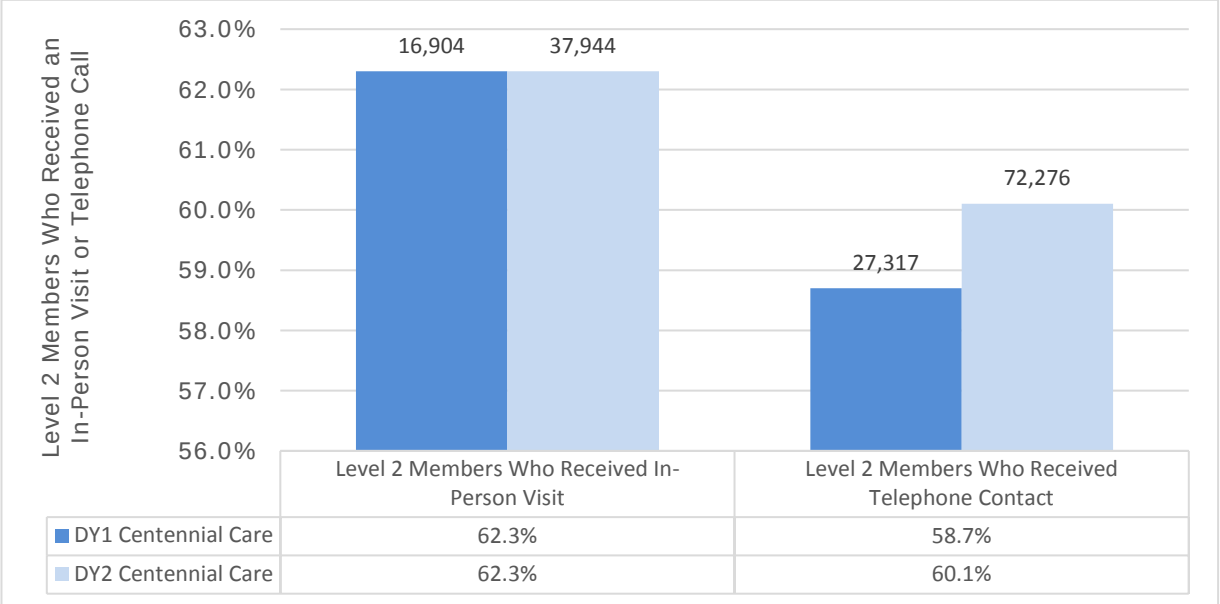
As illustrated, the percentage of Level 2 members who received in-person visits remained steady from DY1 to DY2. Members who received quarterly phone contact increased slightly year-over-year between DY1 and DY2.

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

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

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

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



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

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

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

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

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

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

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

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

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

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

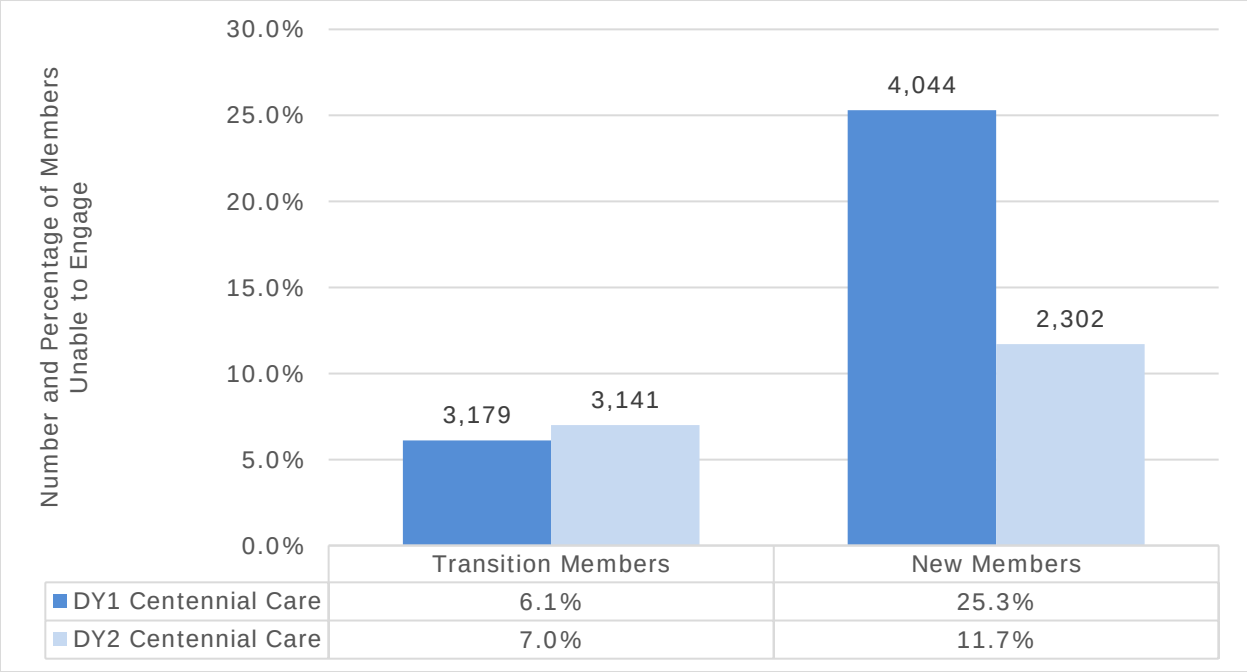
Exhibit 34 below presents results for DY1 and DY2 for the number and percentage of participants for whom a CNA is required, but the MCO is unable to engage the member. The data element specifically citing "unable to locate for care coordination" was not included in HSD Report 6, therefore, the number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

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

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

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

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



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

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

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

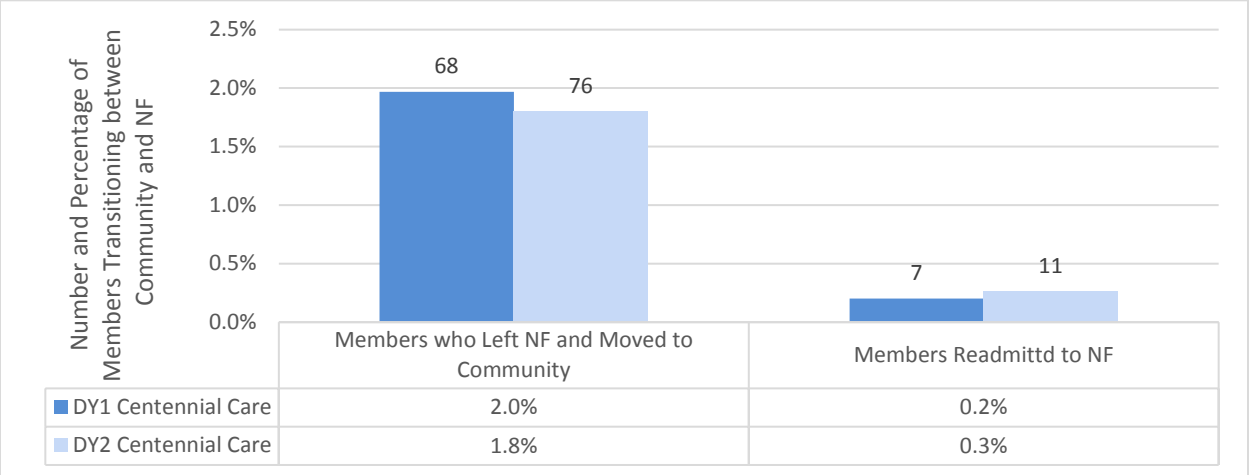
As illustrated, the rate of members moving from a NF into the community declined from 2.0% to 1.8% (an 8.5% change) from DY1 to DY2. The percentage of members who were readmitted into a NF increased from 0.2% to 0.3% (a 28.6% change) over the same period. It must be noted that the overall percentages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

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

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

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

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



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

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

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

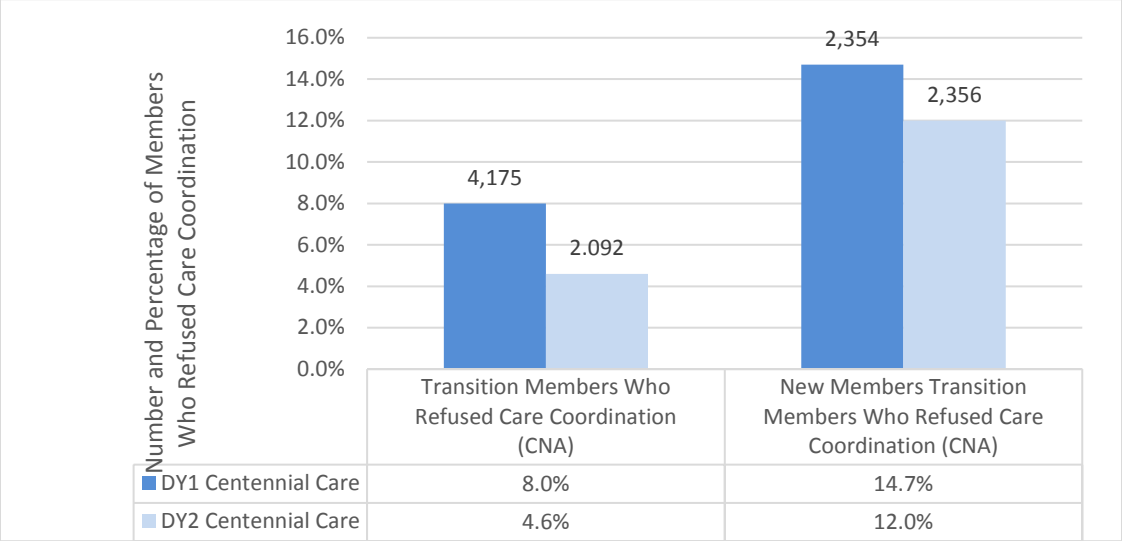
As illustrated, the percentage of both transition and new members who refused a CNA, thereby refusing care coordination services, declined from DY1 to DY2. Overall, the percentage of transition members who refused care coordination declined from 8.0% in DY1 to 4.6% in DY2 (a 42.2% change) and a decline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

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

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

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

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



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

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

Hypothesis 2

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

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

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

Research Question 2.A

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

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

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

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

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

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

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

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

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

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

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

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

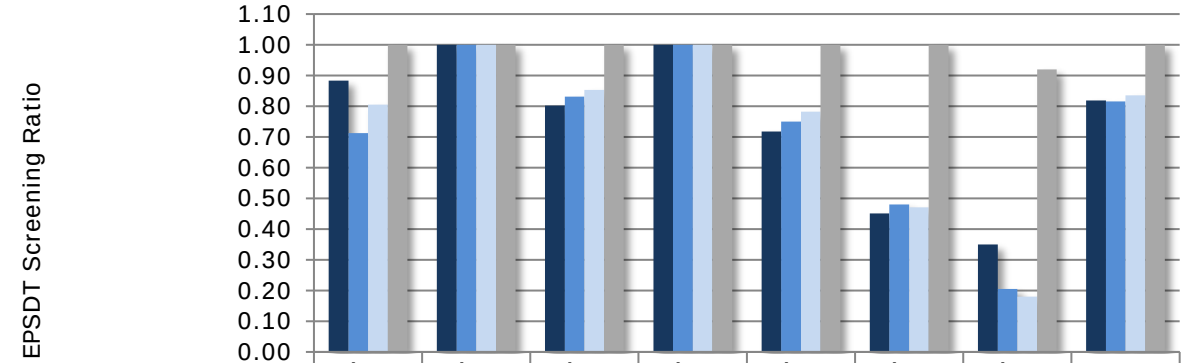
Measure 37 – EPSDT screening ratio.

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

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

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

Exhibit 37 – EPSDT Screening Ratio[50]



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

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

Measure 38 – Annual monitoring for patients on persistent medication.

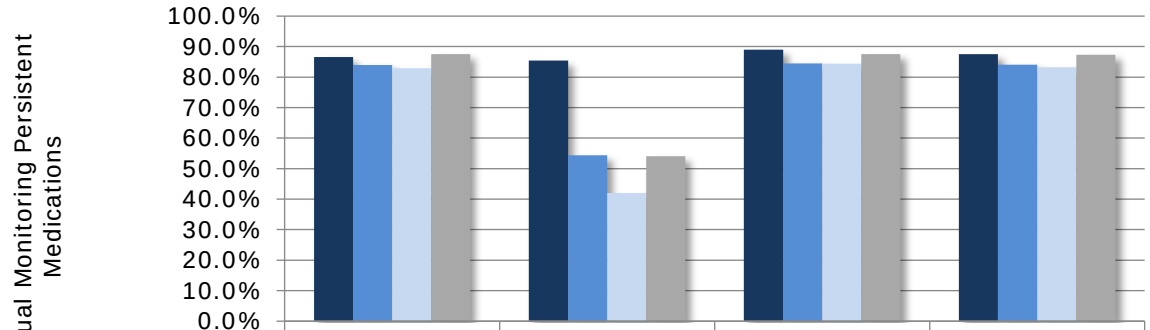
Exhibit 38 presents rates for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national averages for the three subcomponent rates and the aggregate rate for the measure Annual Monitoring for Patients on Persistent Medication.

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

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

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

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



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

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

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

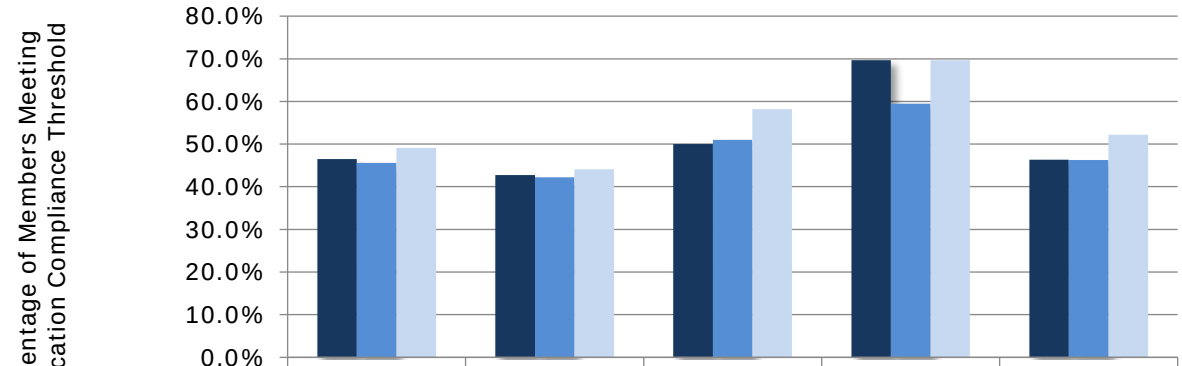
Exhibit 39 presents rates for the 2013 baseline, DY1, and DY2 for the four age cohorts and the aggregate rate for the measure Medication Management for People with Asthma. As illustrated, rates increased in all four age cohorts and in the aggregate from DY1 to DY2. The largest increases at the cohort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

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

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

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

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



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

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

Measure 40 – Asthma medication ratio.

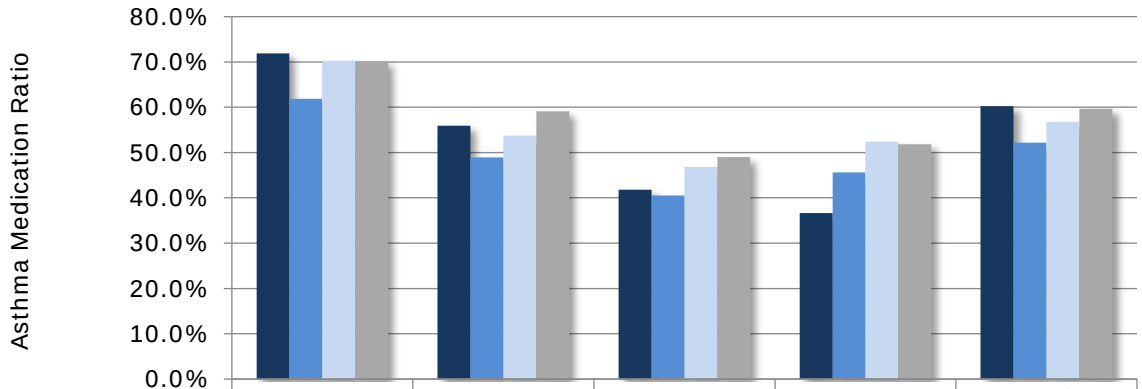
Exhibit 40 presents rates for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national averages for the four age cohorts and the aggregate rate for the measure Asthma Medication Ratio. As illustrated, all age cohorts and the aggregate rate increased from DY1 to DY2. The largest improvement was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

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

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

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

Exhibit 40 – Asthma Medication Ratio[53]



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

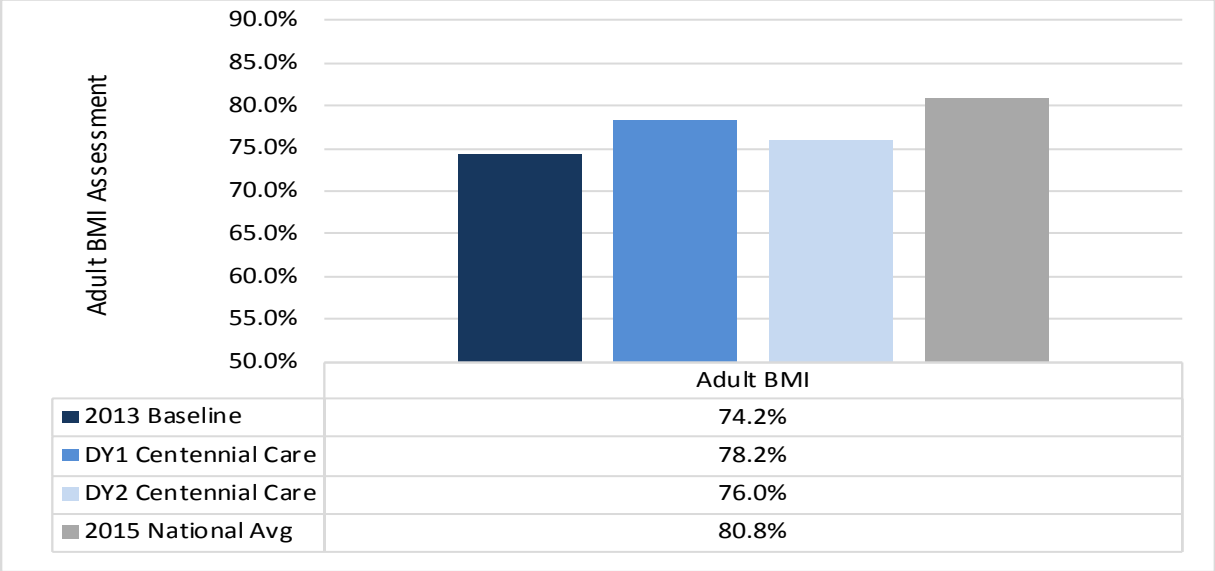
[53] Source: MCO annual HEDIS reports for 2013 – 2015.

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

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

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

Exhibit 41.a – Adult BMI Assessment[54]



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

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

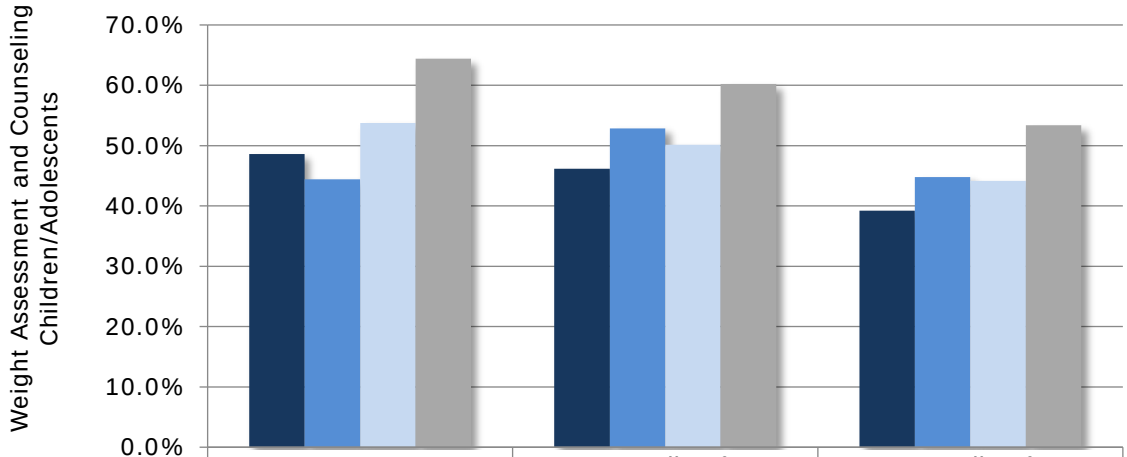
Upon review of the individual MCO performance for the BMI percentile from DY1 to DY2, MHC experienced the largest increase (51.6%), followed by PHP (45.1%). These improvements were statistically significant at the 95% confidence level. During this same period, BCBS exhibited the largest decline in rate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

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

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

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

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



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

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

Measure 42 – Comprehensive diabetes care.

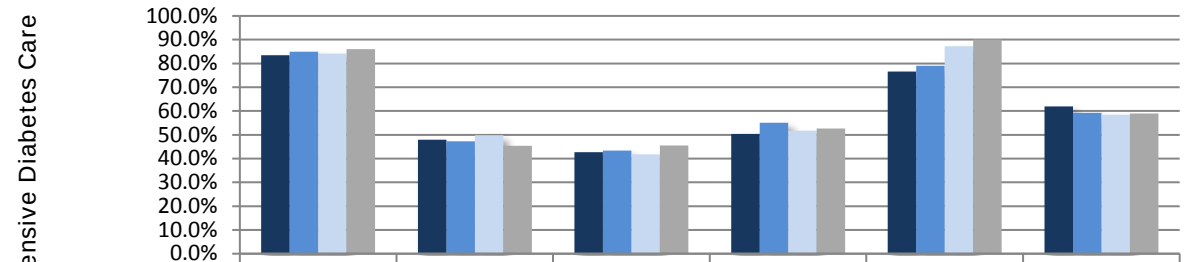
Exhibit 42 presents rates for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national averages for the six subcomponents included in Comprehensive Diabetes Care. As illustrated, one of six rates had a positive increase from DY1 to DY2: medical attention for nephropathy (10.4%). The change in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

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

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

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

Exhibit 42 – Comprehensive Diabetes Care[56]



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

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

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

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

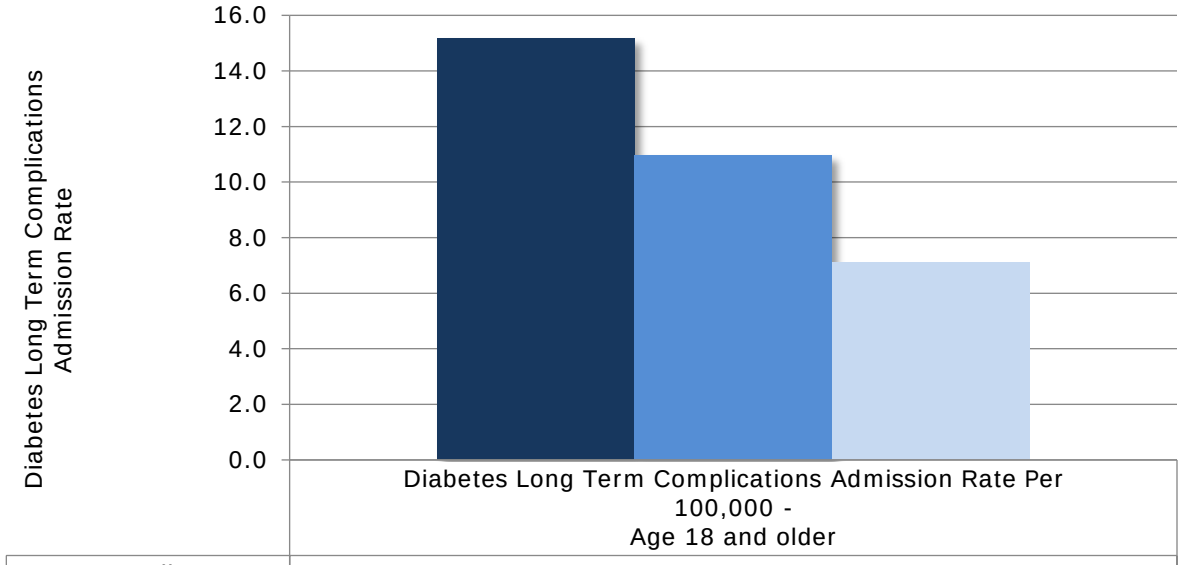
Upon review of the individual MCO performance during the same time period, there was improvement in performance, resulting in a decrease in the rate per 100,000 for admissions due to long term complications from diabetes, for all MCOs: BCBS (-22.7%), MHC (-0.4%), PHP (-10.6%), and UHC (-19.1%).

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

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

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

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



[57] Source: ACS MMIS reports.

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

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

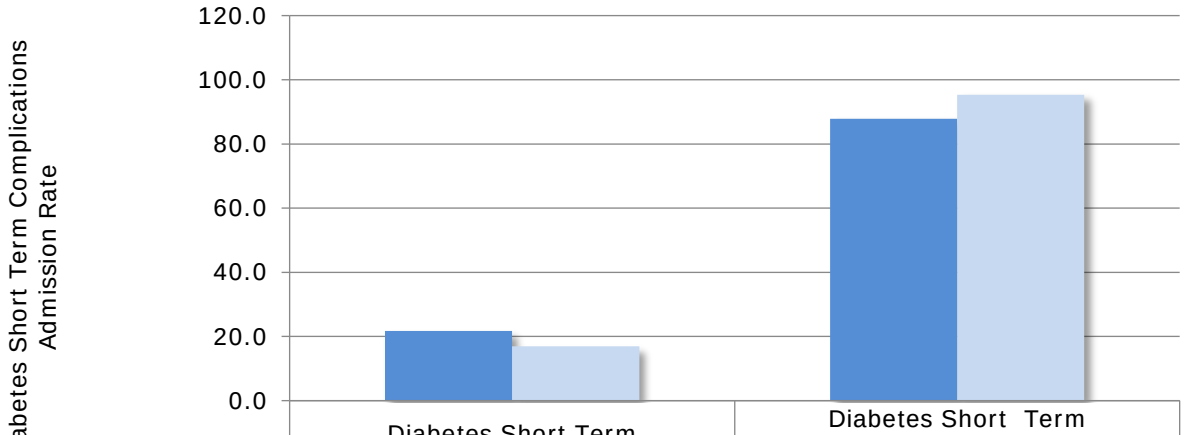
There was an improvement in individual MCO performance over the same time period for three MCOs, resulting in a decrease in rate per 100,000 for admissions of 18-64 year olds due to short term complications from diabetes: BCBS (-15.3%), MHC (-30.2%), and UHC (-39.6%). PHP experienced a 4.1% increase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

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

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

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

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



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

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

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

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

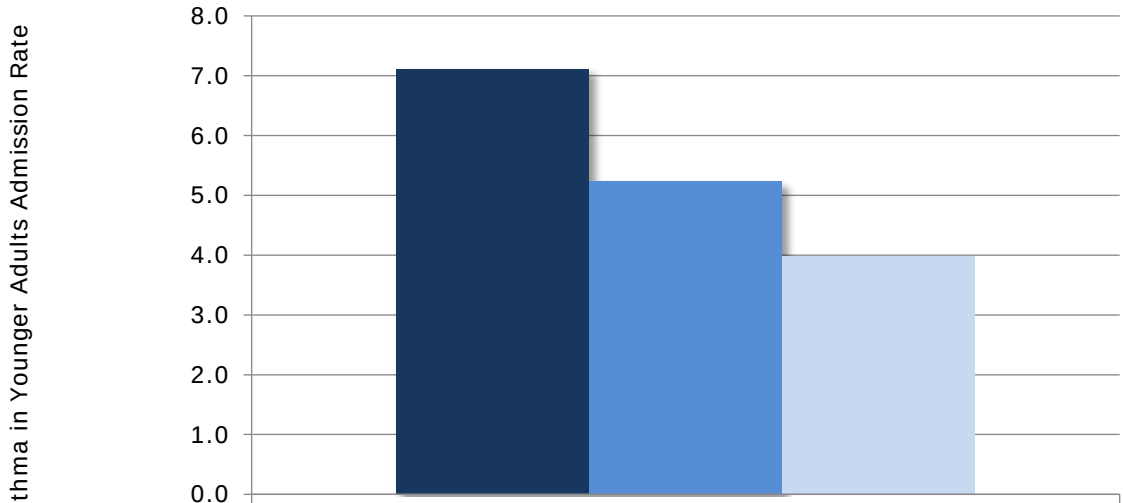
Upon review of the individual MCO performance over the same time period, there were no outliers noted.

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

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

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

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



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

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

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

[59] Source: ACS MMIS reports.

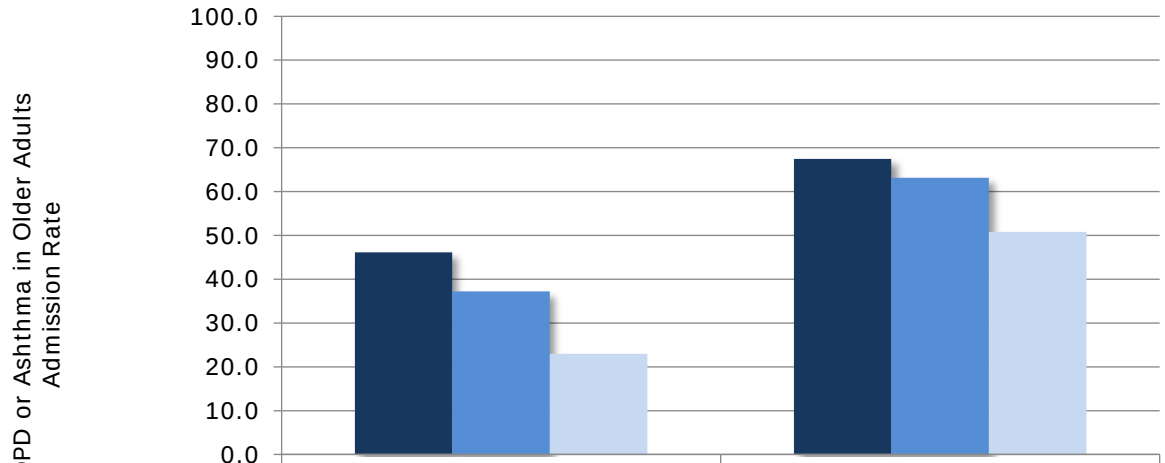
COPD or asthma admission rates declined for MHC (-12.9%), PHP (-56.7%), and UHC (-33.7%) while the rate increased for BCBS (621.4%).

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

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

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

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



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

[60] Source: ACS MMIS reports.

Measure 45 – Ambulatory care sensitive admission rates for hypertension.

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

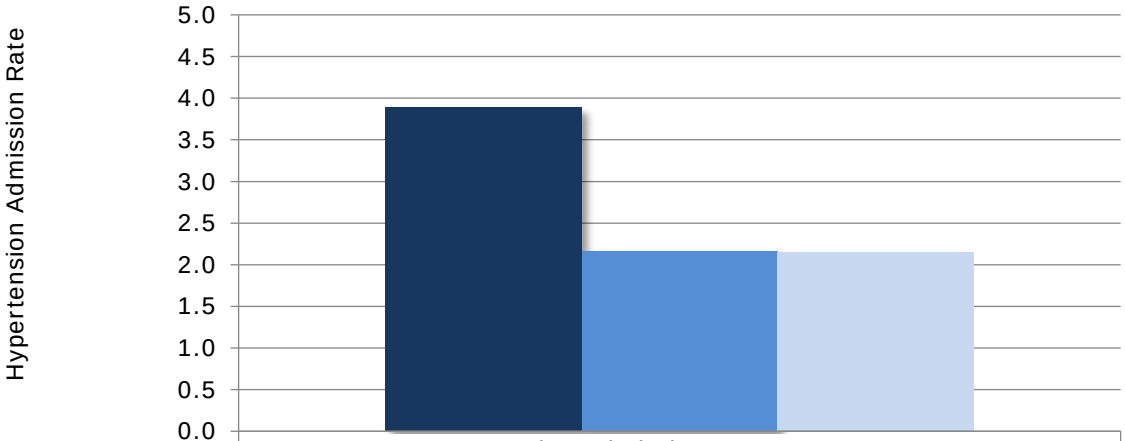
There was an improvement in individual MCO performance over the same time period for two of the MCOs, resulting in a decrease in rate per 100,000 for members with admissions due hypertension: MHC (-28.5%) and UHC (-31.4%). BCBS experienced a 31.2% increase and PHP experienced a 93.3% increase in the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

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

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

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

Exhibit 45 – Hypertension Admissions Rate[61]



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

[61] Source: ACS MMIS reports.

Measure 46 – ACS admission rates for pediatric asthma.

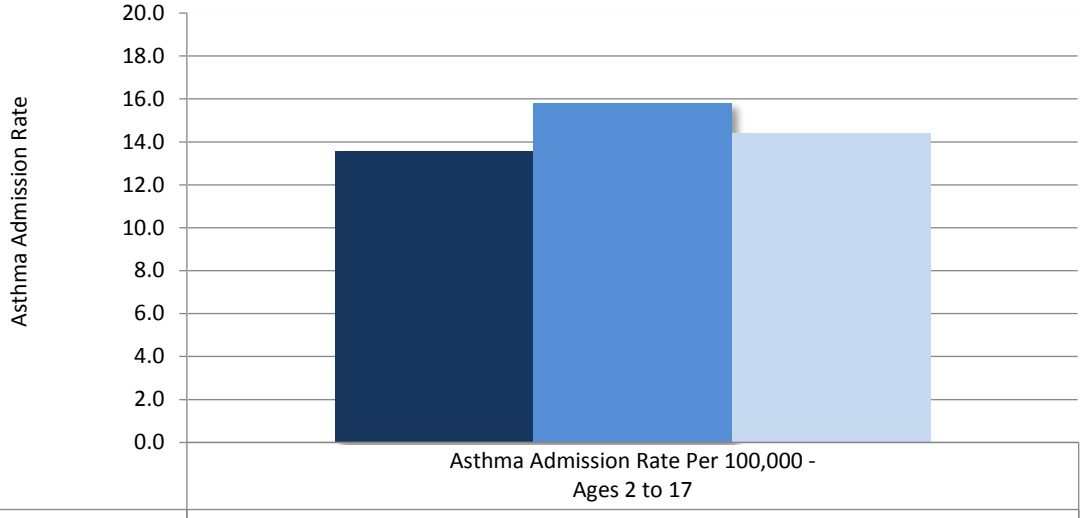
Exhibit 46 presents rates for the 2013 baseline, DY1, and DY2 for the ACS Pediatric Asthma Admission measure for members 2 through 17 years of age. Similar to other admission rate measures, this is an inverse measure where a decreasing rate represents an improvement in performance. As illustrated, there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

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

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

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

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



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

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

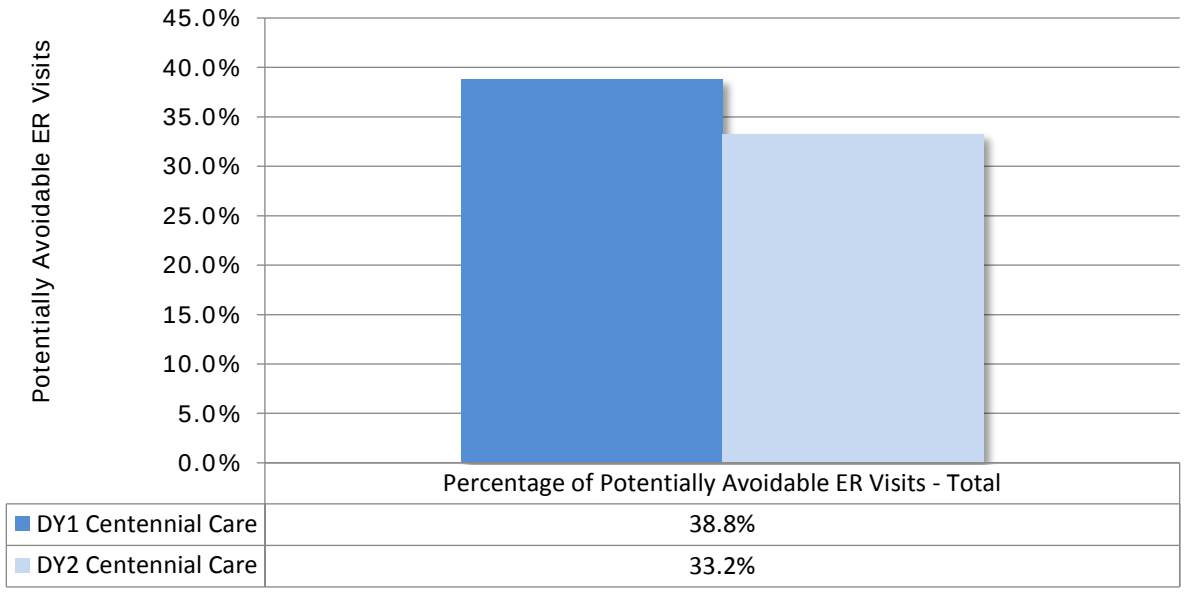
Measure 47 – Number and percentage of potentially avoidable ER visits.

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

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

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

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



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

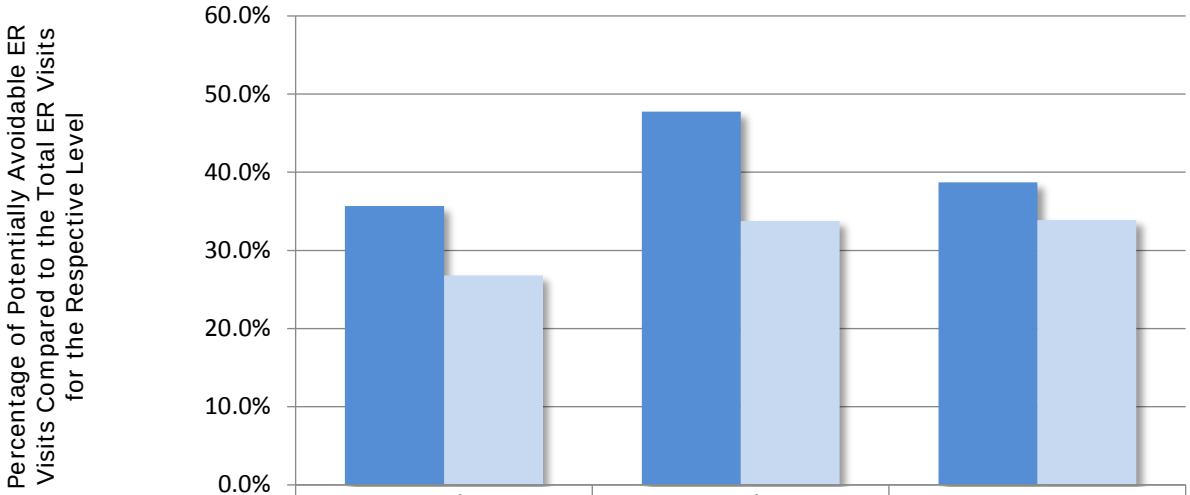
[63] Source: MCO reports for 2014 – 2015 (HSD 40).

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

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

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

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

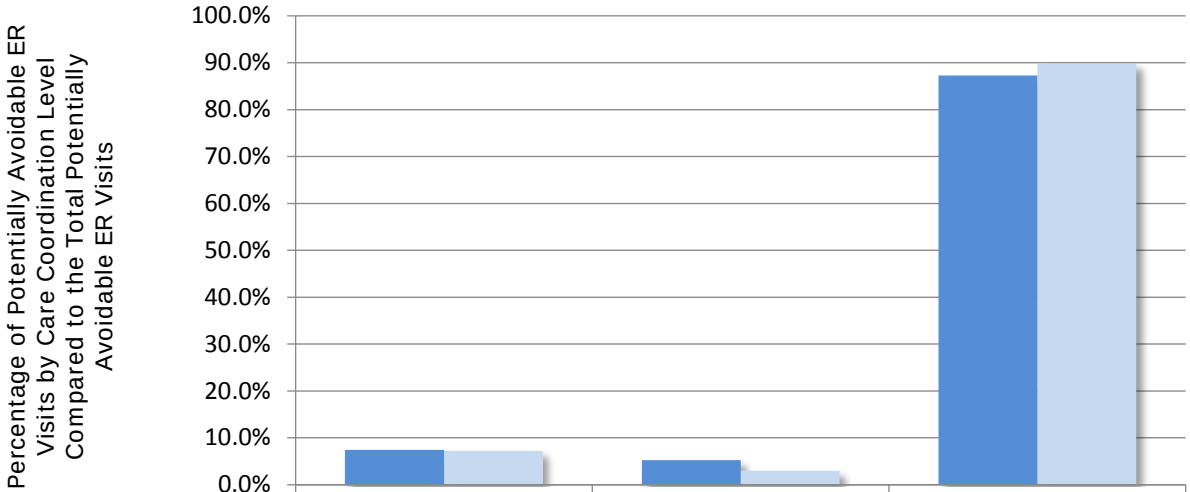


	Level 2	Level 3	No CCL
DY1 Centennial Care	35.7%	47.8%	38.7%
DY2 Centennial Care	26.8%	33.7%	33.9%

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

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

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



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

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

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

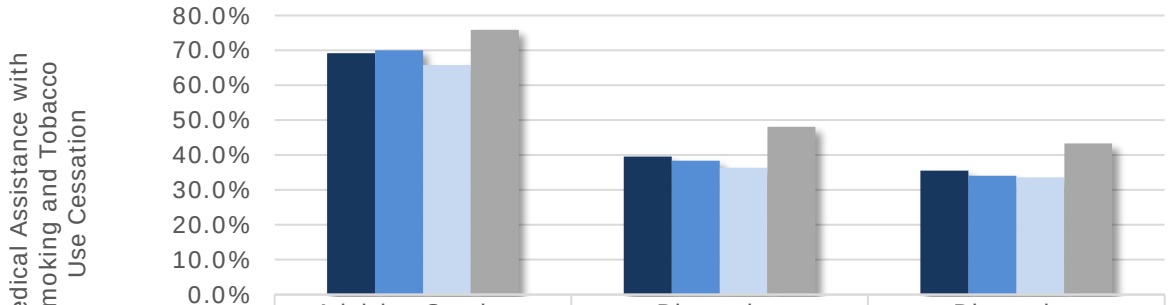
Exhibit 48 presents results for the baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average for the three subcomponents for the Medical Assistance with Tobacco Use Cessation measure. As illustrated, the rate of members who received advice to quit declined by 6.1% from DY1 and DY2. There was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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

[67] Source: MCO Critical Incident Reports.

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

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

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

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

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

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

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

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

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

[68] Source: MCO Critical Incident Reports.

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

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

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

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

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

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

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

[69] Source: MCO Critical Incident Reports.

Measure 50 – Antidepressant medication management.

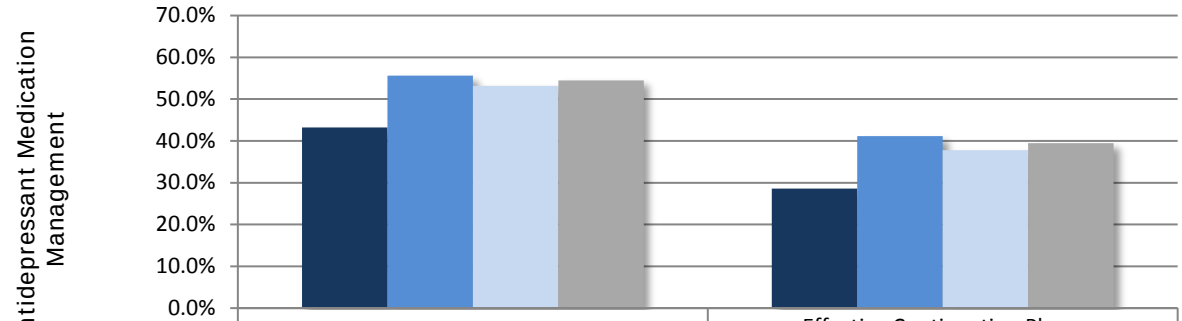
Exhibit 50 presents results for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average for Antidepressant Medication Management. As illustrated, there was a decline in the effective acute phase treatment rate (-4.4%) and a decline in the effective continuation phase treatment rate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

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

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

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

Exhibit 50 – Antidepressant Medication Management[70]



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

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

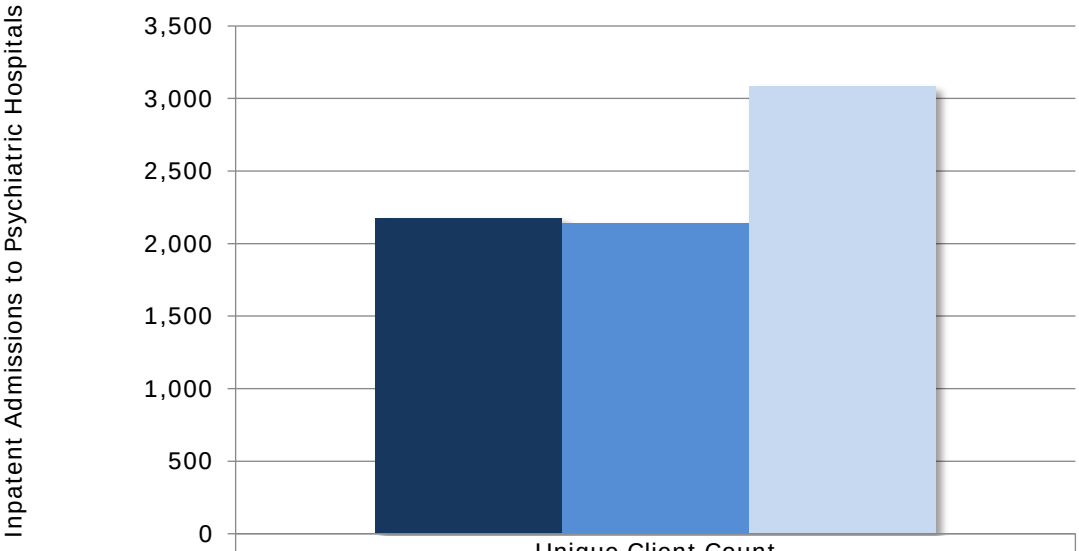
Measure 51 – Inpatient admissions to psychiatric hospitals and residential treatment centers.

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

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

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

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



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

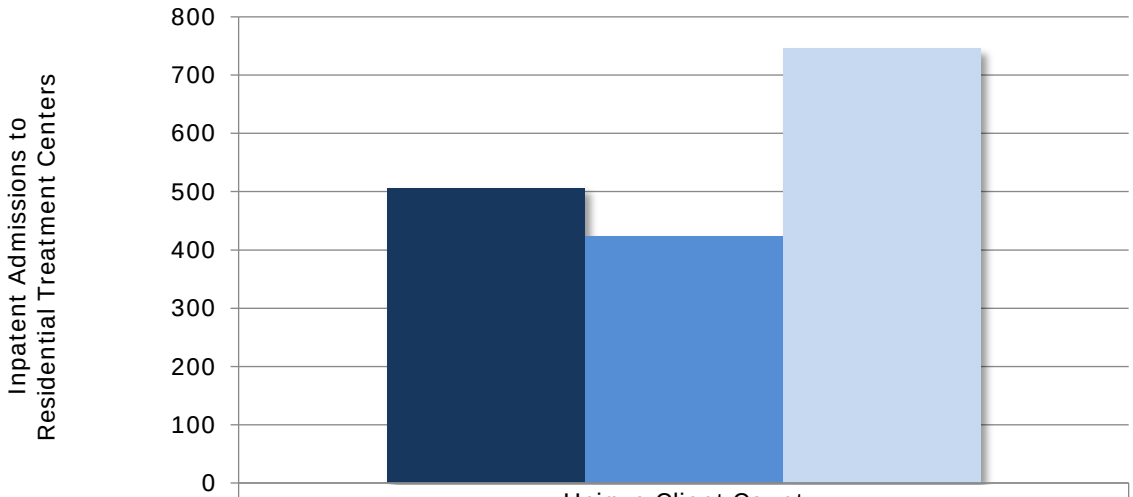
Exhibit 51.b presents counts for Admissions to Residential Treatment Centers (RTCs) in the 2013 baseline, DY1, and DY2. Note that RTCs treat Centennial Care's youth population through age 21. As illustrated, the number of inpatient admissions to RTCs increased 76.1% from DY1 to DY2. Similarly, the count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

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

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

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

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



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

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

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

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

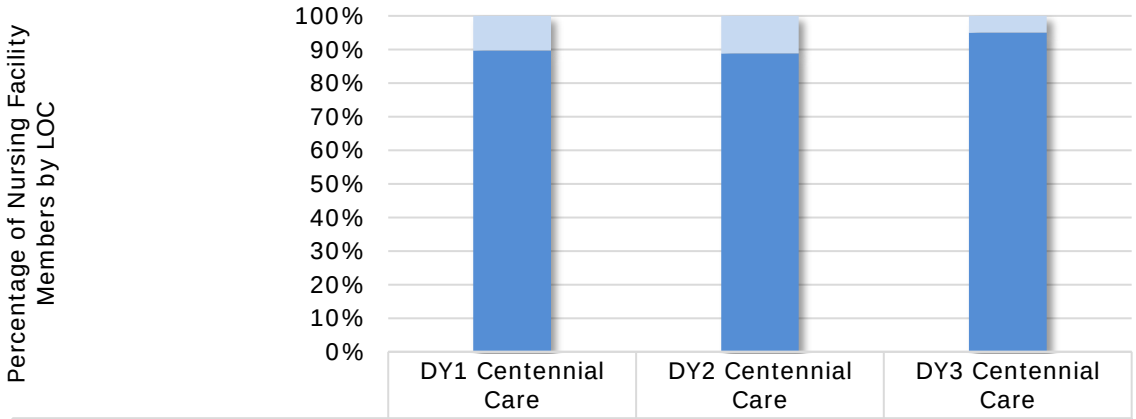
Upon review of the individual MCO performance during the same time period, the percentage of members who met low nursing facility LOC increased for BCBS (2.1%), MHC (28.2%), PHP (13.6%), and UHC (1.2%). Conversely, the percentage of members who met high nursing facility LOC declined across all MCOs: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

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

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

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

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



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

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

Measure 53 – Fall risk intervention.

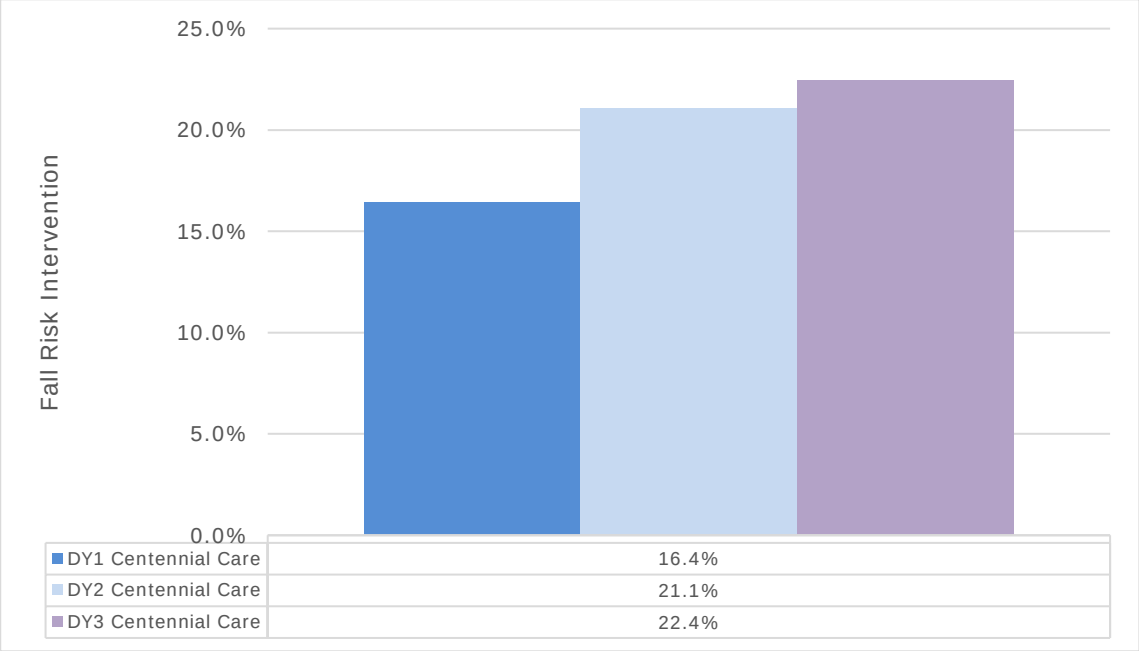
Exhibit 53 presents rates for DY1, DY2, and DY3 for Fall Risk Intervention, which measures members 65 years of age and older who have had a fall or problem with balance in the 12 months and who were seen by a provider and who received a fall risk intervention. It should be noted that the data source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

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

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

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

Exhibit 53 – Fall Risk Intervention[74]



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

Research Question 2.B

Is care integration effective under Centennial Care?

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

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

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

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

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

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

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

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

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

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

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

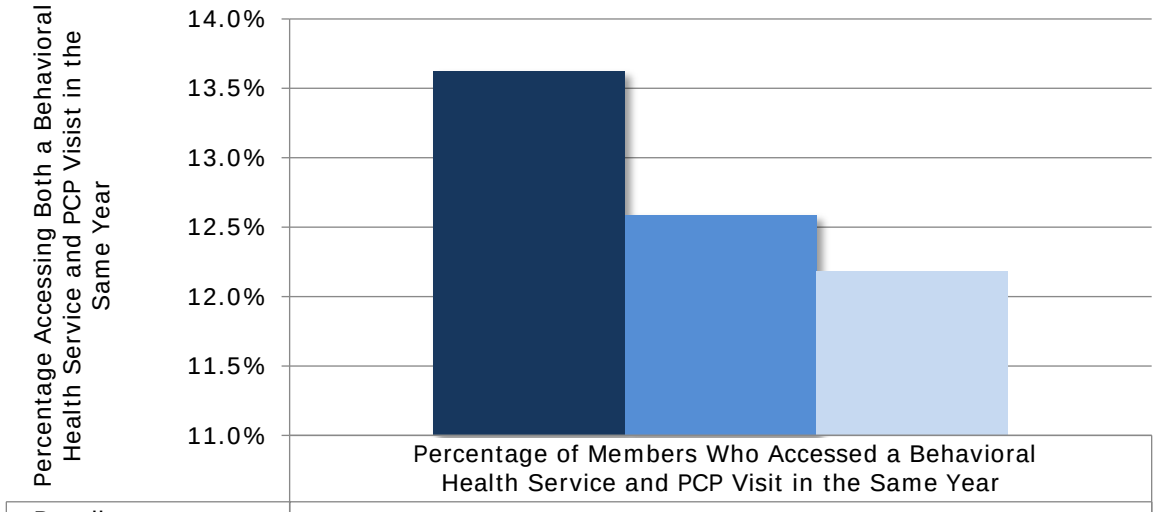
Exhibit 54 presents results for the 2013 baseline, DY1, and DY2 for the Percentage of the Population Accessing a Behavioral Health Service and a PCP Visit in the Same Year. As illustrated, there was a 3.2% decline in the percentage of members that accessed both a BH service and PCP visit in the same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

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

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

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

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



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

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

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

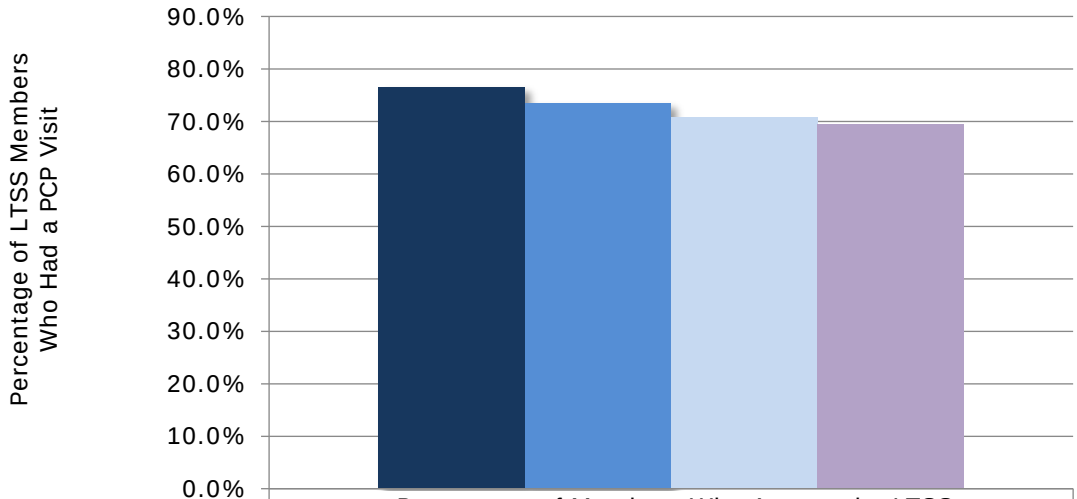
Exhibit 55 presents results for the 2013 baseline, DY1, DY2, and DY3 for the Percentage of the LTSS Population that Received a PCP Visit in the Same Year. This measure has been modified to isolate the LTSS population as the eligible population, or denominator. Previously this measure used the entire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

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

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

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

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



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

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

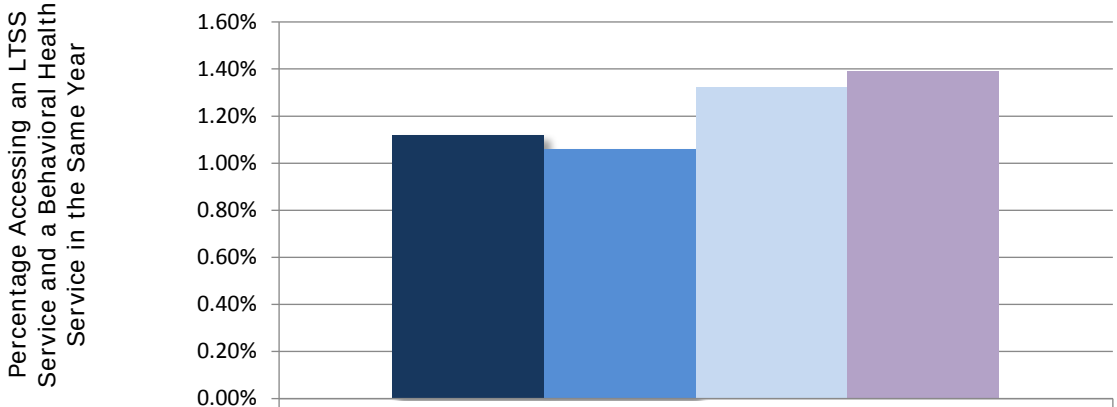
Measure 56 – Percentage of the population accessing an LTSS service and a behavioral health visit in the same year.

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

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

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

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



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

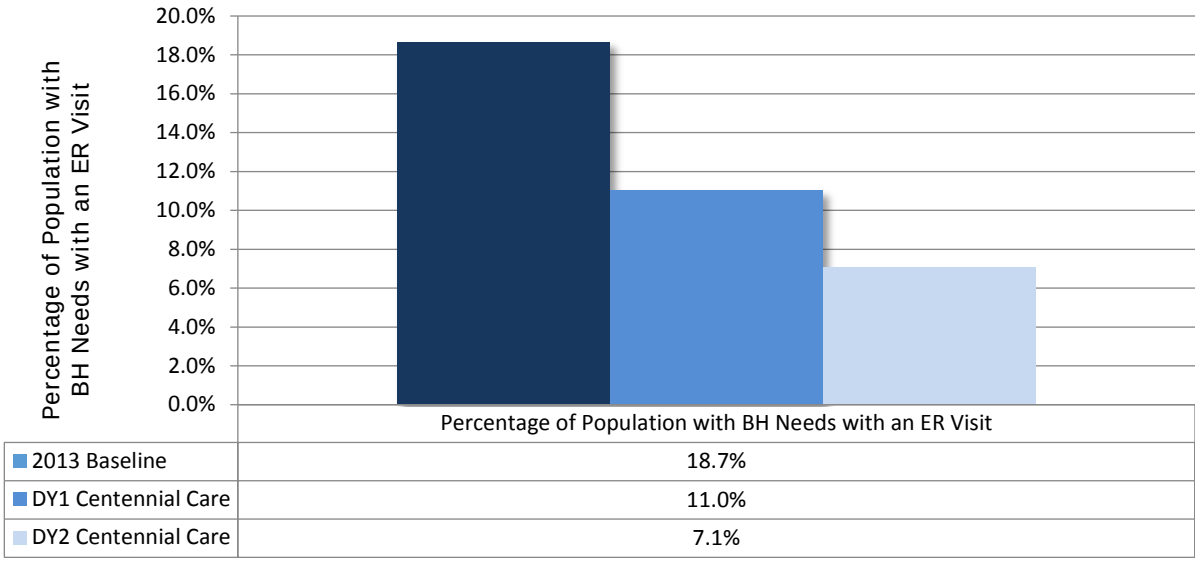
[77] Source: LTSS and BH MMIS reports.

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

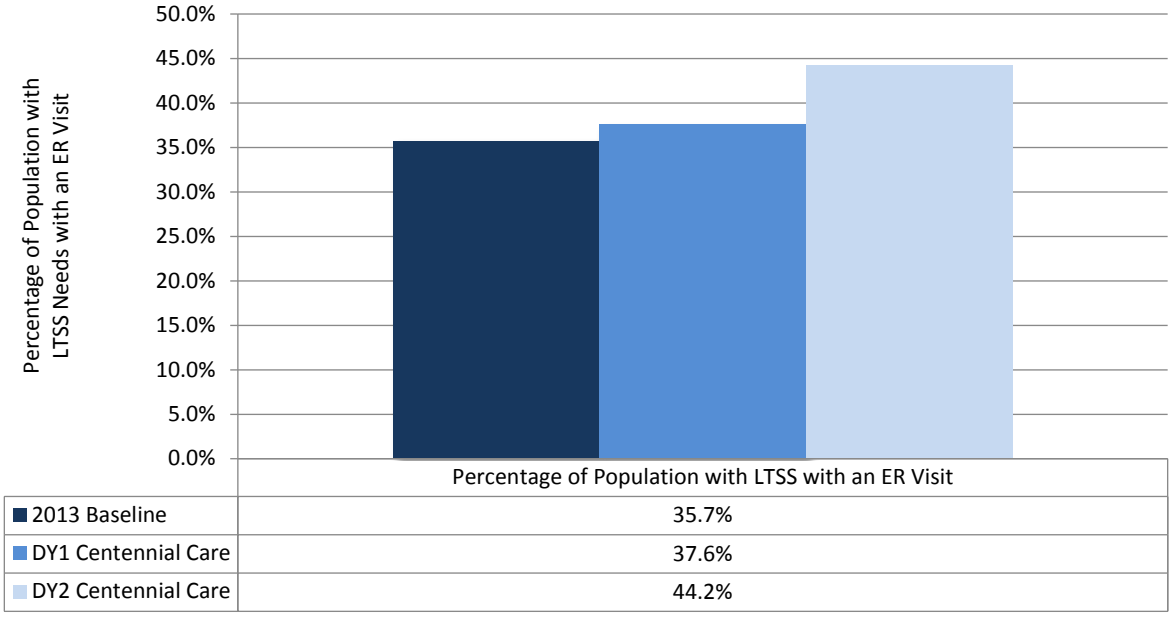
Exhibit 58.a below presents rates for the 2013 baseline, DY1, and DY2 for the measure Percentage of the Population with LTSS Needs with an ER Visit. As illustrated, there was an unfavorable increase in the total rate from 37.6% in DY1 to 44.2% in DY2 (a 17.7% change).

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

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

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

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



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

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

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

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

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

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

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

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

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

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

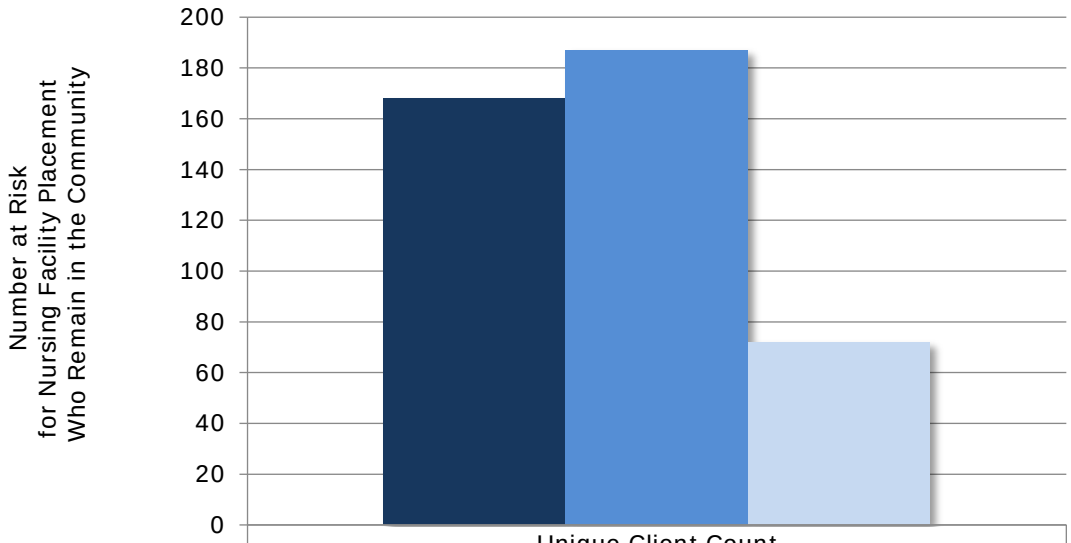
Exhibit 59 presents results for the 2013 baseline, DY1, and DY2 for the Number at Risk for Nursing Facility Placement Who Remain in the Community. As illustrated, the number of members that transitioned from NFs into the community declined 61.5% from DY1 to DY2. Similarly, the rate also declined (57.1%)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

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

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

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

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



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

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

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

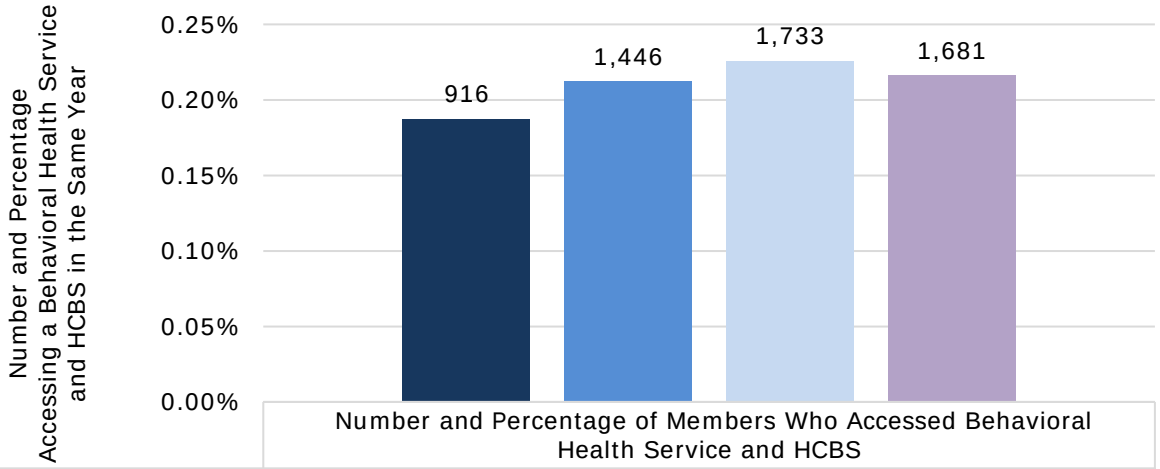
Exhibit 60 below presents results for the 2013 baseline, DY1, DY2, and DY3 for the Number and Percentage of Members who Accessed a Behavioral Health Service that also Accessed HCBS in the Same Year. As illustrated, there was a slight decrease in the percentage of members accessing both BH and HCBS services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

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

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

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

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



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

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

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

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

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

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

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

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

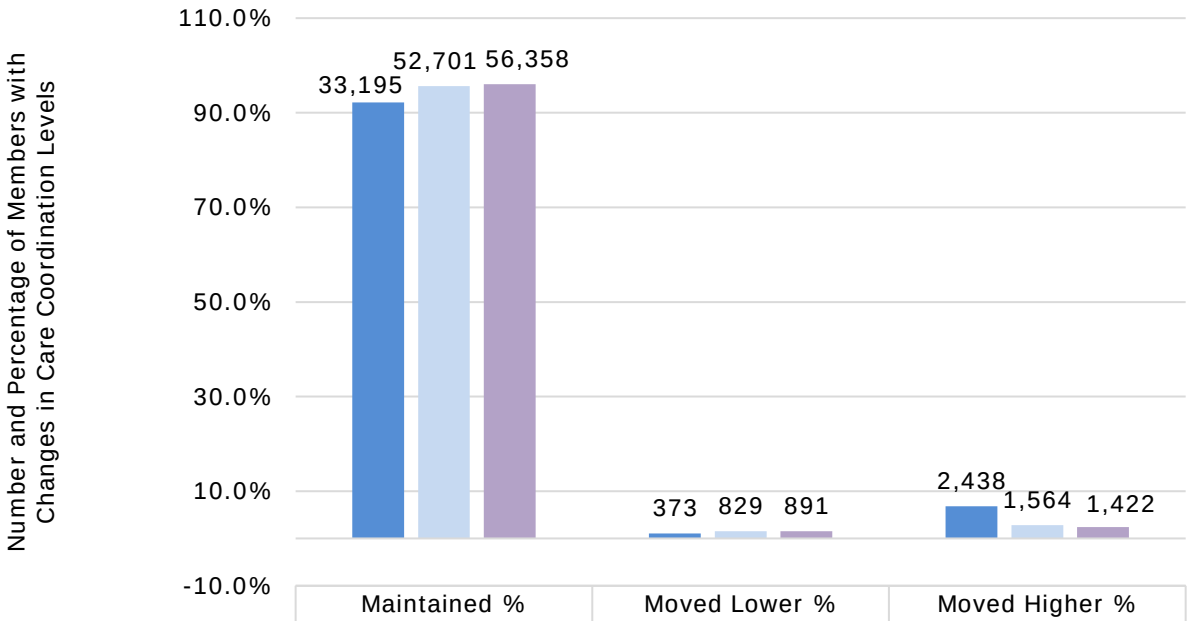
The average number of members that moved to a lower care coordination level increased 138.9% and the percentage of members that moved to a lower care coordination level with respect to the average total number of members receiving care coordination increased by 46.6% over the same period.

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

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

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

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



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

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

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

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

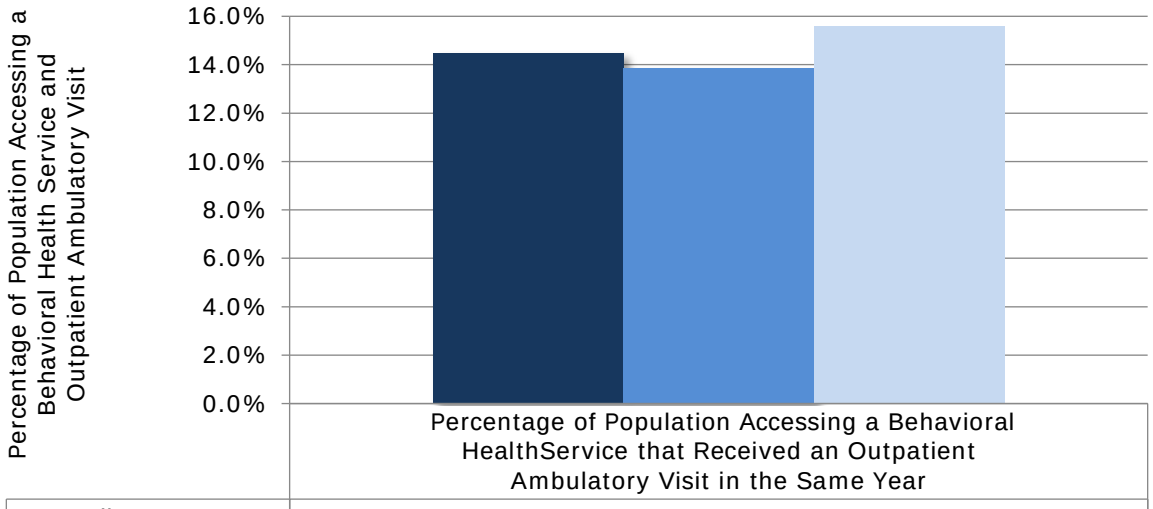
Upon review of the individual MCO performance over the same time period, there were increases in the percentage of members accessing a BH service that received an outpatient ambulatory visit in the same year for BCBS (25.9%), MHC (9.8%), PHP (3.6%), and UHC (19.2%).

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

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

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

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



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

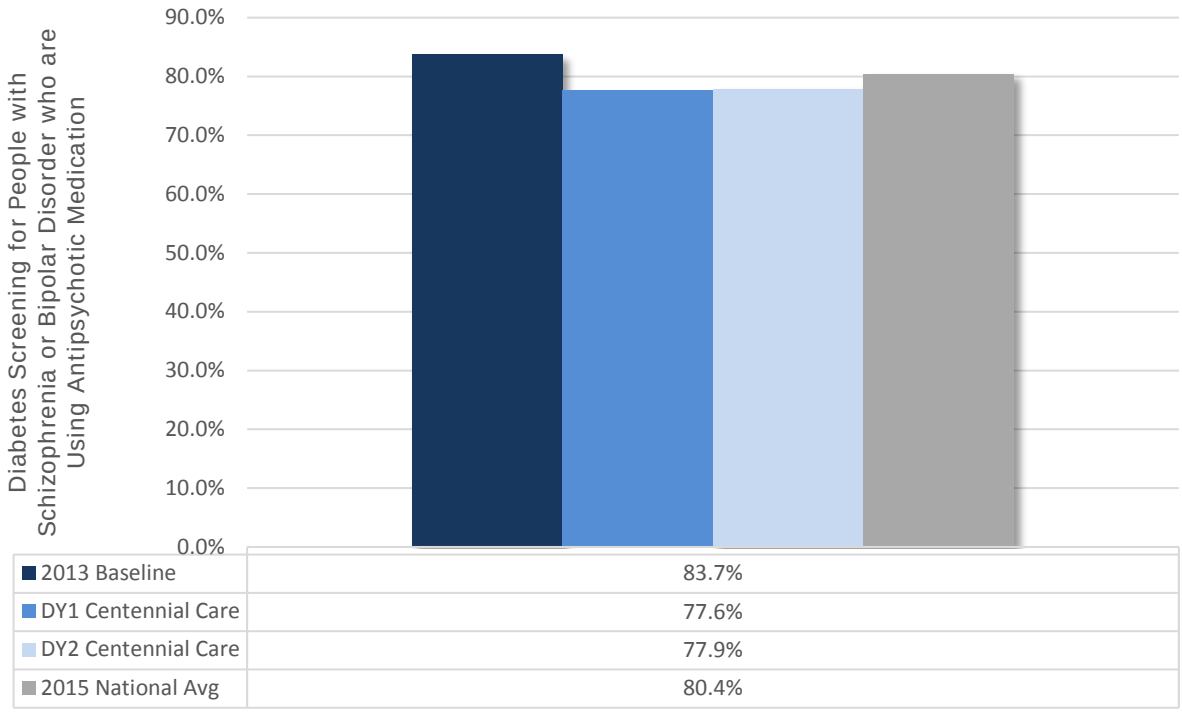
[85] Source: BH Clients with Outpatient Ambulatory Visits MMIS reports.

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

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

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

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



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

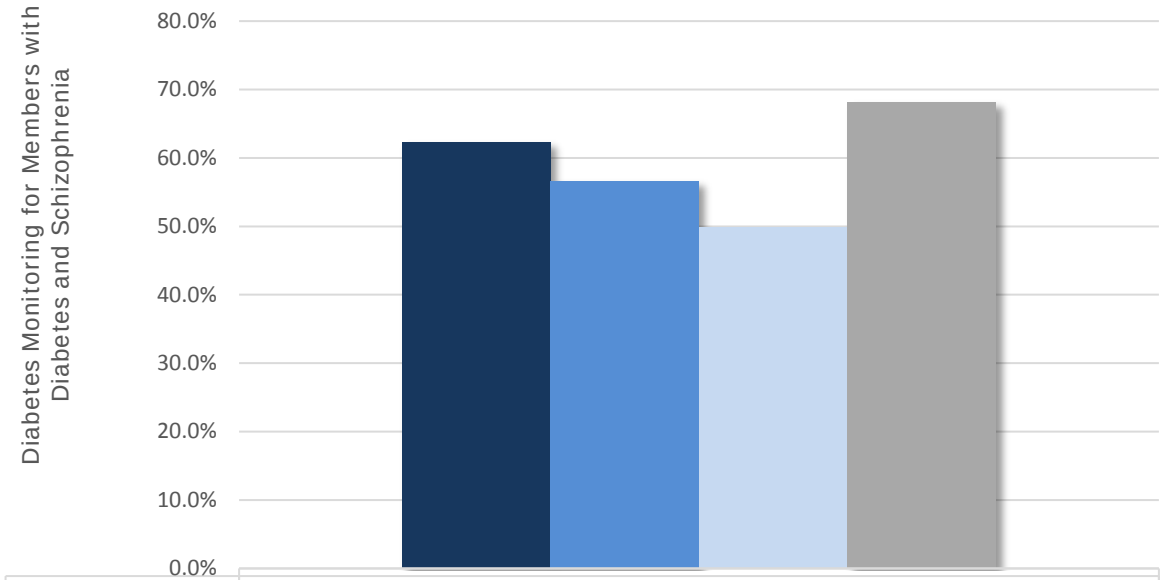
[86] Source: MCO annual HEDIS reports for 2013 – 2015.

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

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

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

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



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

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

Hypothesis 3

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

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

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

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

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

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

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

Research Question 3.A

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

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

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

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

New Mexico saw improvement from the baseline to DY3 for total program expenditures, costs per member, and costs per user for five out of six MEGs for each of the three measures. There were also increases in most subcomponents for the use of mental health services, increases in the use of substance abuse services and use of HCBS, and positive shifts for pharmacy utilization where usage of generic drugs is more prevalent than brand drugs. Inpatient services exceeding $50,000 and all cause readmission rates have also seen favorable declines.

There were mixed results for 3 out of 15 measures, particularly measures with multiple subcomponents. These include utilization by category of service, where there were favorable decreases in average length of stay for acute and specialty hospitals and favorable decreases in higher LOC NF use while lower LOC NF use increased, a positive utilization shift to less costly services. Other categories such as non-emergency transportation had unfavorable increases in utilization from the baseline to DY3. The use of institutional care experienced increases in days per thousand but decreases in admits per thousand. Use of inpatient and mental health/substance abuse services also saw increases in services in the RTC setting though the psychiatric hospital setting remained fairly consistent.

There was a decline in performance from the baseline to DY3 for diagnostic imaging costs, hospital costs, and for ED use, all of which experienced unfavorable increases. However it is important to note that diagnostic imaging costs remain very immaterial and ED utilization has trended down year-over-year from DY1 to DY3.

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

Measure 65 – Total program expenditures.

Exhibit 65.a and Exhibit 65.b presents total costs by MEG for DY1, DY2, and DY3 compared to the baseline projected program expenditures. In Exhibit 65.a and Exhibit 65.b, "DYX STC" indicates the projected dollar cost for a particular MEG by multiplying the PMPM for a particular demonstration year by the actual member months for the same demonstration year. The goal of the Centennial Care Waiver is to meet budget neutrality requirements, which is to say that the total "with waiver" costs do not exceed the total "without" waiver costs. As illustrated, total costs by MEG for DY1, DY2, and DY3 were below cost projections for all MEGs apart from the NF LOC Dual group[88]. Total DY3 costs as of March 6, 2017 were 21.8% below the STC cost projections for DY3.

The Group VIII (Medicaid-expansion eligible adults) and TANF groups experienced the greatest dollar difference between projected costs and actual costs in DY3. The SSI-Dual group also experienced material differences between projected and actual costs in DY3, where actual costs were 30.7% below projected costs and made up the third largest dollar difference.

The significant difference in comparing baseline projected costs to actual expenditures for the NF LOC group is partially attributable to the large PMPM cost cap that was estimated for this group. Under STC 107 that cost cap is $4,936.92 PMPM for DY1, and will increase by 3.1% per year through the end of DY5. The reportable data from CMS-64 Schedule C and the HSD Budget Neutrality tables submitted to CMS indicate relatively lower costs for the NF LOC population. In addition, with less than 3,000 member months attributed to this MEG, the variance between actual costs from costs estimated from STC 107 is greater than the variance between actual and estimated costs under MEGs with a larger population base.

In regards to the NF LOC Dual group, HSD determined that the estimated PMPM for budget neutrality included a population of healthy duals. Healthy duals have a very low cost PMPM which, when weighted across the whole NF LOC Dual population, pushed the estimated PMPM down. The final CMS approved population attributed to NF LOC Dual for the waiver demonstration did not include the aforementioned healthy duals, yet their costs were included in the estimated PMPM under STC 107. With the waiver demonstration population for NF LOC Dual not including healthy duals, the PMPM cost increased relative to the original estimates and NF LOC Dual exceeds the budget neutrality "test one" limit.

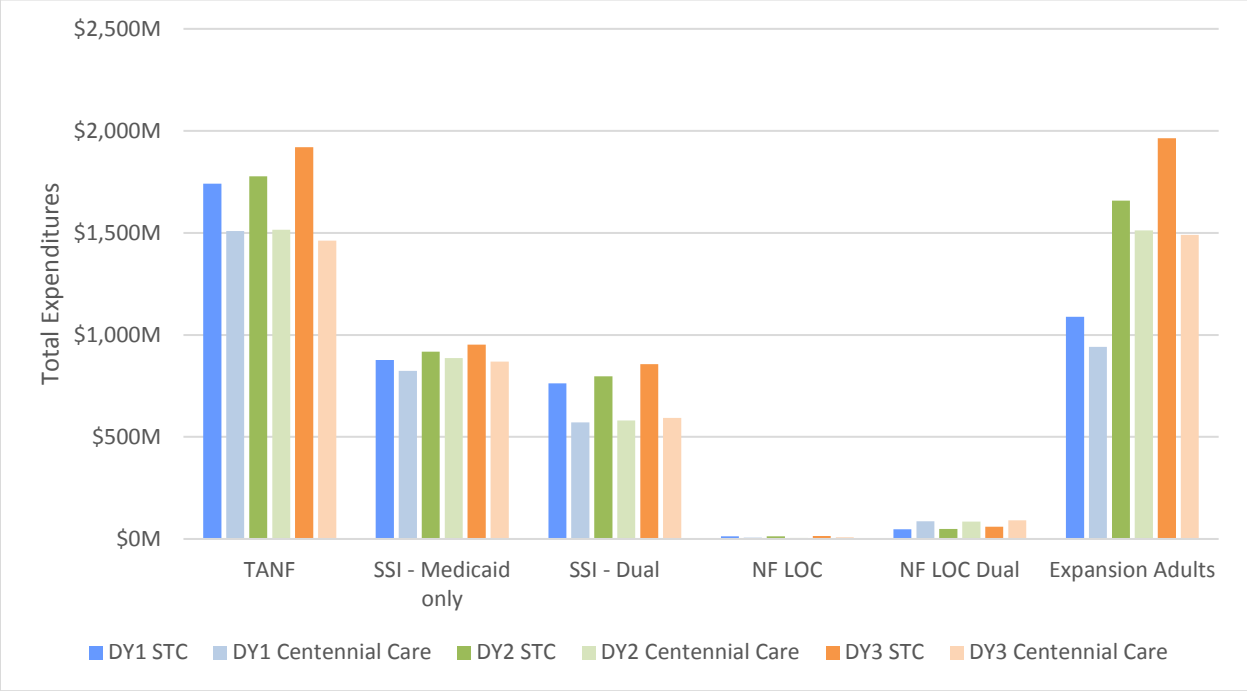
The footnote of Exhibit 65.b below specifies that the cost comparison for TANF members does not include the costs and member months for children living in families with incomes between 133% and 185% of the federal poverty level as those costs and member months were reported under CHIP. Expenses reported in CHIP are not subject to budget neutrality, except when the State has exhausted its CHIP allotment (STCs 99 to 101). The impact of excluding the costs and member months of these children in TANF is that the reportable costs and member months for TANF were understated relative to the baseline.

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

Statistical significance was not calculated for this measure as the aggregate nature of the information was not appropriate for statistical significance testing.

[88] The MEGs "NF LOC" and "NF LOC Dual" are equivalent to the MEGs "217-like Medicaid" and "217-like Group Dual" respectively as defined by STC 18.

Exhibit 65.a – DY1 to DY3 Total Program Expenditures by MEG[89]



[89] Source: Budget Neutrality tables, sourced from CMS-64 Schedule C, Quarter End December 2016.

Exhibit 65.b – DY1 to DY3 Total Program Expenditures by MEG[90]

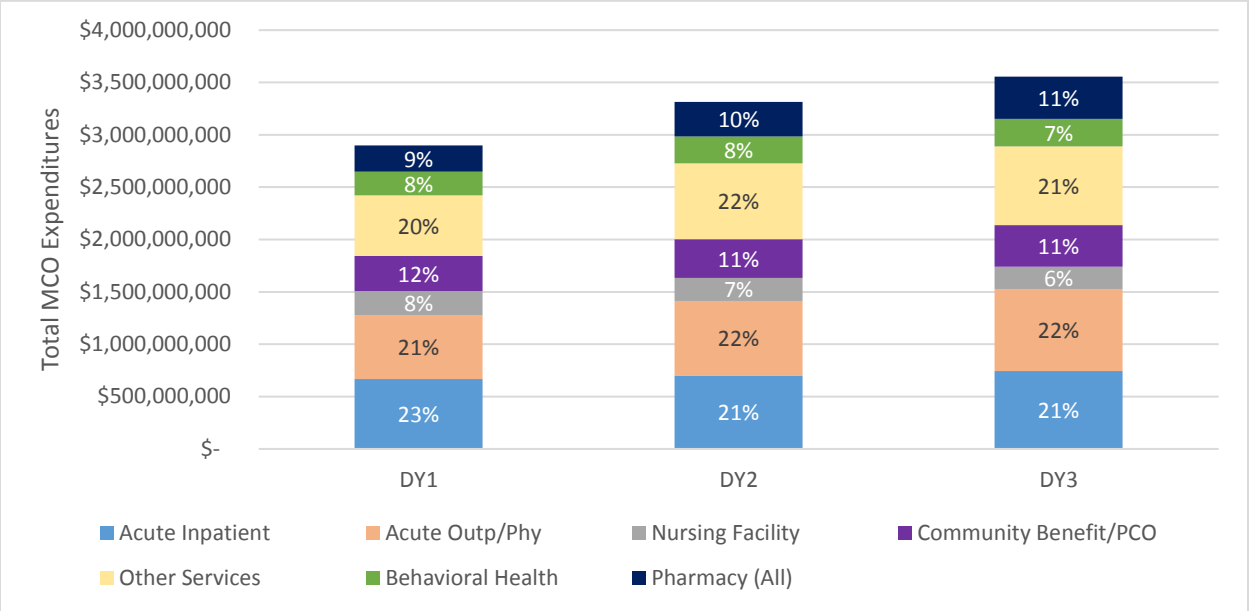
Year and Measure		TANF	SSI - Medicaid only	SSI - Dual	NF LOC	NF LOC Dual	Expansion Adults	Uncompensated Care	HQII	Total
2014	STC	$1,741,829,516	$877,545,542	$762,650,368	$13,403,738	$47,908,778	$1,088,709,391	$68,889,322	$0	**$4,600,936,654**
	Centennial Care	$1,508,687,841	$824,511,459	$570,589,894	$6,662,907	$86,784,521	$941,763,087	$68,889,323	$0	**$4,007,889,032**
	Measured Over/ (Under) Baseline	($233,141,675)	($53,034,083)	($192,060,474)	($6,740,831)	$38,875,743	($146,946,304)	$1	$0	**($593,047,622)**
	% Measured Over / (Under) Baseline	-13.4%	-6.0%	-25.2%	-50.3%	81.1%	-13.5%	0.0%	0.0%	**-12.9%**
2015	STC	$1,777,899,080	$917,996,550	$796,997,595	$12,369,818	$49,614,962	$1,657,978,073	$68,889,322	$2,824,462	**$5,284,569,863**
	Centennial Care	$1,515,008,918	$886,963,101	$581,487,225	$5,631,972	$84,975,937	$1,511,725,079	$68,889,323	$2,824,462	**$4,657,506,017**
	Measured Over/ (Under) Baseline	($262,890,162)	($31,033,449)	($215,510,370)	($6,737,846)	$35,360,975	($146,252,994)	$1	$0	**($627,063,846)**
	% Measured Over / (Under) Baseline	-14.8%	-3.4%	-27.0%	-54.5%	71.3%	-8.8%	0.0%	0.0%	**-11.9%**
2016	STC	$1,920,328,873	$952,799,905	$856,853,167	$14,827,775	$60,473,905	$1,963,790,716	$68,889,322	$5,764,727	**$5,843,728,390**
	Centennial Care	$1,462,319,710	$868,969,133	$593,582,822	$7,962,326	$90,826,284	$1,490,021,951	$51,667,000	$5,764,727	**$4,571,113,953**
	Measured Over/ (Under) Baseline	($458,009,163)	($83,830,772)	($263,270,345)	($6,865,449)	$30,352,379	($473,768,765)	($17,222,322)	$0	**($1,272,614,437)**
	% Measured Over / (Under) Baseline	-23.9%	-8.8%	-30.7%	-46.3%	50.2%	-24.1%	-25.0%	0.0%	**-21.8%**

[1]The expenses and member months of the optional children who qualified for Medicaid under Sections 1902(a)(10)(A)(u)(IX) and 1902(l)(2) were included in MEG1 – TANF and Related for the calculation of the PMPM cost "without waiver", but the actual expenses and member months of this group of children were reported under the CHIP program, which is not subject to budget neutrality testing.

The Evaluation also examined data summarized by Mercer which demonstrates the distribution of total program expenditures by service category in DY1, DY2, and DY3. As Exhibit 65.b illustrates, the distribution of program expenditure has been relatively stable throughout DY1 to DY3. Notable trends from DY1 to DY3 include the steady increase in expenditures for pharmacy. There has also been a steady decrease in expenditures for NF, which aligns to program goals for moving members to the community care setting when able. Overall, acute inpatient, acute outpatient/physician, and other services remain as the largest spending categories. In particular, acute inpatient and acute outpatient/physician services together make up over 40% of total program expenditures in each year. Meanwhile NF has been the least expensive service category, costing less than 10% of program expenditures in each year.

[90] Source: Budget Neutrality tables, sourced from CMS-64 Schedule C, Quarter End December 2016. The 2016 uncompensated care payment consists of three quarters of payments; one quarter of payments have not been made and reported as of December 31, 2016

Exhibit 65.b – DY1 to DY3 Total Program Expenditure Distribution by Service Category[91]



Measure 66 – Costs per member.

Exhibit 66.a presents the annual cost per member for DY1, DY2, and DY3 compared to the baseline PMPM costs. In the exhibit, "DYX STC" is the PMPM caps by MEG for that particular demonstration year. The budget neutrality goal of the Centennial Care Waiver is to ensure that the "with waiver" PMPM costs for each MEG do not exceed the "without waiver" PMPM costs for each MEG. Furthermore, the State is not at risk for total expenditures as a result of increases in membership. As illustrated, and consistent with measure 65, the costs for all MEGs stayed below the MEG PMPM cap throughout DY1 to DY3 apart from the NF LOC Dual group.

In addition, the PMPM costs for all MEGs experienced decreases in the range of 1.0% to 12.5% from DY2 to DY3, apart from the NF LOC group. The PMPM reduction is particularly noteworthy for the Expansion Adults population, which is population that had not previously had access to these benefits and has continued to experience tremendous enrollment growth since DY1. The PMPM costs for this group in particular decreased 12.5% from DY2 to DY3 and decreased 3.1% from DY1 to DY3.

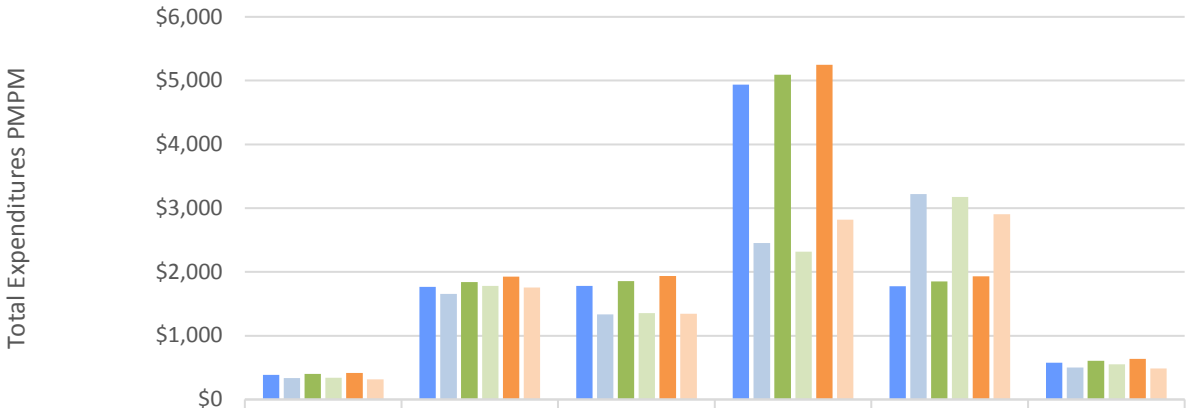
The aggregate program PMPM decreased 7.6% from DY2 to DY3 and decreased 2.6% from DY1 to DY3. These decreases in PMPM by MEG demonstrates that the Centennial Care program is experiencing success with respect to cost containment, a principal goal of the program.

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

Statistical significance was not calculated for this measure as the aggregate nature of the information was not appropriate for statistical significance testing.

[91] Source: Data summarized by Mercer based on financial statements submitted by MCOs. MCO expenditures are not the same as Centennial Care total program expenditures, though cost distribution across categories of service would generally align.

Exhibit 66.a – DY1 to DY3 PMPM Expenditures by MEG[92]

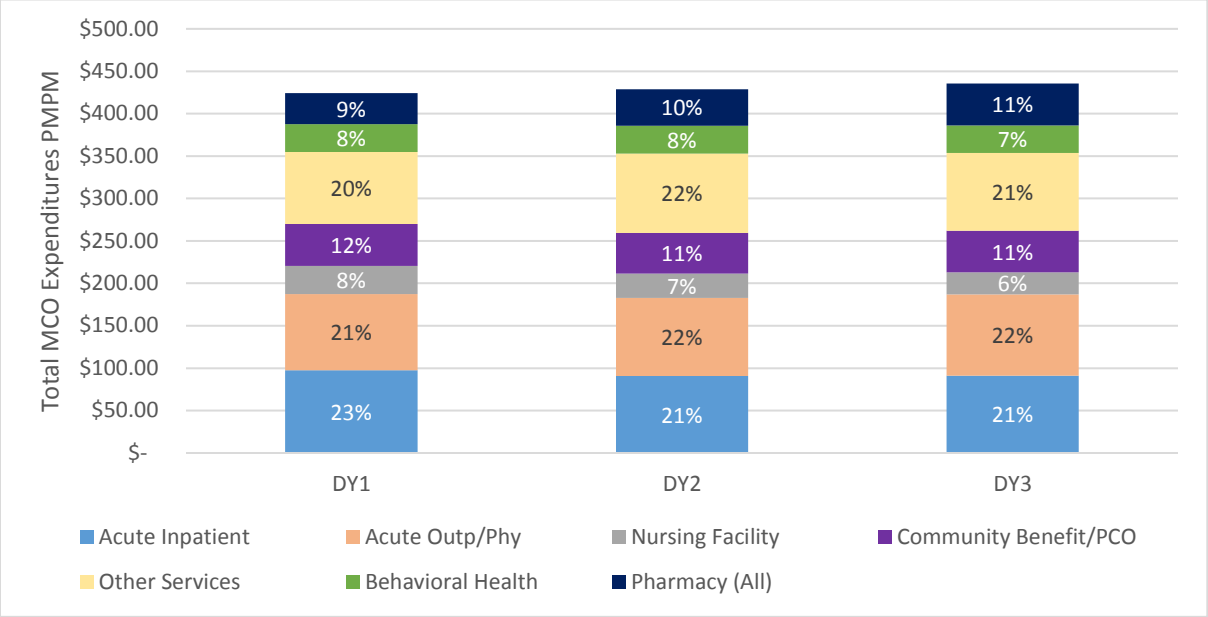


	TANF	SSI - Medicaid only	SSI - Dual	NF LOC	NF LOC Dual	Expansion Adults
DY1 STC	$385.80	$1,763.90	$1,780.77	$4,936.92	$1,776.90	$577.87
DY1 Centennial Care	$334.16	$1,657.30	$1,332.31	$2,454.11	$3,218.77	$499.87
DY2 STC	$400.77	$1,842.83	$1,857.34	$5,090.46	$1,853.31	$607.34
DY2 Centennial Care	$341.51	$1,780.53	$1,355.11	$2,317.68	$3,174.18	$553.77
DY3 STC	$416.32	$1,925.21	$1,937.21	$5,248.77	$1,933.00	$638.31
DY3 Centennial Care	$317.03	$1,755.82	$1,342.00	$2,818.52	$2,903.19	$484.32

The Evaluation also examined data summarized by Mercer which shows the distribution of PMPM program expenditures by service category in DY1, DY2, and DY3. As Exhibit 66.b illustrates, and consistent with measure 65 above, the distribution of PMPM expenditure has been relatively stable throughout DY1 to DY3. Notable trends from DY1 to DY3 include the steadily increasing PMPM expenditures for pharmacy and steadily decreasing PMPM expenditures for NF. Overall, acute inpatient, acute outpatient/physician, and other services remain as the largest spending categories PMPM. In particular, acute inpatient and acute outpatient/physician services together make up over 40% of total PMPM expenditure in each year. Meanwhile nursing facility has been the least expensive service category, making up less than 10% of total PMPM expenditures in each year.

[92] Source: Budget Neutrality tables, sourced from CMS-64 Schedule C, Quarter End December 2016.

Exhibit 66.b – DY1 to DY3 PMPM Expenditure Distribution by Service Category[93]



[93] Source: Data summarized by Mercer based on financial statements submitted by MCOs. MCO expenditures are not the same as Centennial Care total program expenditures, though cost distribution across categories of service would generally align.

Measure 67 – Costs per user of services.

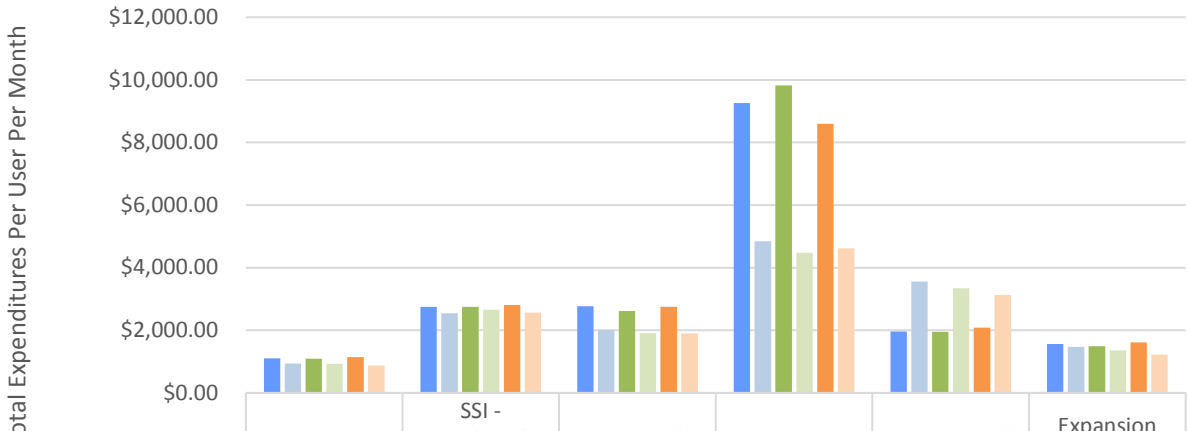
Exhibit 67 presents the calculated costs per user by MEG for DY1, DY2, and DY3 compared to the baseline costs. In the exhibit, "DYX STC" is the cost-per-user caps by MEG. As the exhibit illustrates, and consistent with the measure 65, the costs for all MEGs, apart from NF LOC Dual, remained below the MEG cost-per-user cap throughout DY1 to DY3.

Consistent with results from the PMPM costs measure, the Per User Per Month (PUPM) costs for all MEGs experienced decreases from DY2 to DY3, apart from the NF LOC group. These decreases in costs, which ranged from 0.3% to 10.0%, demonstrate that the Centennial Care program is experiencing success with respect to cost containment.

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

Statistical significance was not calculated for this measure as the aggregate nature of the information was not appropriate for statistical significance testing.

Exhibit 67 – Cost per User of Services[94]



	TANF	SSI - Medicaid only	SSI - Dual	NF LOC	NF LOC Dual	Expansion Adults
DY1 STC	$1,099.95	$2,747.08	$2,770.82	$9,263.12	$1,963.64	$1,560.03
DY1 Centennial Care	$939.42	$2,540.92	$2,017.46	$4,848.78	$3,555.20	$1,474.95
DY2 STC	$1,090.73	$2,747.84	$2,617.08	$9,825.11	$1,952.04	$1,487.91
DY2 Centennial Care	$929.44	$2,654.95	$1,909.41	$4,473.37	$3,343.27	$1,356.66
DY3 STC	$1,148.13	$2,809.02	$2,746.76	$8,595.81	$2,082.65	$1,609.30
DY3 Centennial Care	$874.29	$2,561.87	$1,902.81	$4,615.84	$3,127.95	$1,221.05

[94] CMS-64 Schedule C , Quarter End December 2016; Cost Per User of Service MMIS reports.

Measure 68 – Utilization by category of service.

Exhibit 68 presents the utilization of various service categories across PH and LTSS for the Q1 2014 baseline, DY1, DY2, and DY3.

For inpatient PH services for specialty hospitals, the trend of decreasing average length of stay has continued throughout the baseline to DY3. There were smaller increases in days per 1,000 and larger increases in admits per 1,000 from DY2 to DY3 as well as from the baseline to DY3, resulting in decreases in the average length of stay in both periods. For acute hospitals, the average length of stay increased slightly in DY3 compared to DY2, but overall both the days per 1,000 and admits per 1,000 have decreased substantially from the baseline.

For other PH services, there were minor decreases in visits per 1,000 for outpatient surgeries and outpatient hospital visits to urgent care from DY2 to DY3. However, both subcomponents experienced increases in utilization from the baseline to DY3 (17.5% for outpatient surgeries and 59.7% for urgent care). There was also a significant increase (282.1%) in non-emergent transportation trips from DY2 to DY3.

Inpatient LTSS services (including acute hospitals, specialty hospitals, and hospital swing bed) showed mixed performance results across time periods. From DY2 to DY3, utilization of both acute and specialty hospital services generally experienced increases in days per 1,000, admits per 1,000, and average length of stay, although the average length of stay in specialty hospitals experienced a slight decrease. However, overall from the baseline to DY3, utilization of both acute and specialty hospital services experienced substantial decreases in the same measures; only average length of stay in specialty hospitals experienced a significant increase. Utilization of hospital swing bed appears to experience decreases in performance from the baseline to DY3, but there is limited data to draw sound conclusions.

Overall from the baseline to DY3, NF care for high levels of care experienced decreases in utilization, while low levels of care experienced increases in utilization. This trend is desirable as shifting utilization from higher levels of care to lower levels of care should result in a net decrease in healthcare costs.

Other LTSS services that experienced increases in utilization from the baseline to DY3 include the use of personal care services (73.6% for T1019, 207.5% for 99509), outpatient urgent care (128.1%), and non-emergent transportation (15,563.2%). Outpatient surgery visits experienced a slight decrease (-9.5%) from the baseline to DY3.

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

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

Exhibit 68 – Utilization by Category of Service[95]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	Diff. from Baseline	DY3	Diff. from DY2	Diff. from Baseline
UTILIZATION BY CATEGORY OF SERVICE										
PHYSICAL HEALTH										
Inpatient Hospital - Acute	Days per 1,000	2,152.6	2,086.0	-3.1%	1,634.6	-21.6%	-24.1%	1,392.6	-14.8%	-35.3%
Inpatient Hospital - Acute	Admits per 1,000	281.0	281.5	0.2%	275.6	-2.1%	-1.9%	220.5	-20.0%	-21.5%
Inpatient Hospital - Acute	Average Length of Stay	7.7	7.4	-3.2%	5.9	-20.0%	-22.6%	6.3	6.5%	-17.6%
Inpatient - Specialty Hospital	Days per 1,000	19.0	16.2	-14.5%	21.2	30.4%	11.6%	25.5	20.3%	34.2%
Inpatient - Specialty Hospital	Admits per 1,000	1.1	0.9	-13.9%	1.3	46.1%	25.8%	2.1	58.8%	99.7%
Inpatient - Specialty Hospital	Average Length of Stay	17.8	17.7	-0.7%	15.8	-10.7%	-11.3%	12.0	-24.2%	-32.8%
Ambulatory Surgery Centers - Outpatient Surgeries	Vists per 1,000	14.3	17.4	21.2%	18.0	3.5%	25.5%	16.8	-6.4%	17.5%
Outpatient Hospital - Urgent Care	Vists per 1,000	31.3	44.6	42.5%	50.2	12.6%	60.4%	50.0	-0.5%	59.7%
Non-Emergent Transportation - Non-Capitated	Trips per 1,000	0.0	0.0	N/A	73.6	N/A	N/A	281.1	282.1%	N/A
LTSS										
Nursing Facility State Owned - High Level of Care	Days per 1,000	328.4	171.9	-47.7%	164.5	-4.3%	-49.9%	159.7	-2.9%	-51.4%
Nursing Facility State Owned - Low Level of Care	Days per 1,000	1,849.5	1,881.6	1.7%	1,923.9	2.2%	4.0%	2,054.5	6.8%	11.1%
Nursing Facility Private - High Level of Care	Days per 1,000	6,436.2	3,564.5	-44.6%	1,631.5	-54.2%	-74.7%	2,408.3	47.6%	-62.6%
Nursing Facility Private - Low Level of Care	Days per 1,000	19,719.3	21,622.5	9.7%	22,997.1	6.4%	16.6%	21,081.8	-8.3%	6.9%
Hospital Swing Bed - High Level of Care	Days per 1,000	2.3	2.7	15.7%	0.0	-100.0%	-100.0%	0.2	N/A	-93.0%
Hospital Swing Bed - Low Level of Care	Days per 1,000	0.9	3.1	247.5%	2.1	-33.2%	132.2%	0.0	-100.0%	-100.0%
Personal Care Option - T1019	15 Minute Intervals per 1,000	447,638.9	495,883.9	10.8%	705,853.0	42.3%	57.7%	777,046.9	10.1%	73.6%
Personal Care Option - 99509	1 Hour Intervals per 1,000	39,516.6	54,837.6	38.8%	161,393.9	194.3%	308.4%	121,531.8	-24.7%	207.5%
Inpatient Hospital - Acute	Days per 1,000	2,429.4	2,748.6	13.1%	1,308.4	-52.4%	-46.1%	1,552.0	18.6%	-36.1%
Inpatient Hospital - Acute	Admits per 1,000	292.4	309.9	6.0%	209.2	-32.5%	-28.5%	211.7	1.2%	-27.6%
Inpatient Hospital - Acute	Average Length of Stay	8.3	8.9	6.8%	6.3	-29.5%	-24.7%	7.3	17.2%	-11.7%
Inpatient - Specialty Hospital	Days per 1,000	377.1	361.4	-4.1%	106.0	-70.7%	-71.9%	132.2	24.7%	-64.9%
Inpatient - Specialty Hospital	Admits per 1,000	54.1	52.8	-2.5%	5.5	-89.6%	-89.9%	7.3	33.2%	-86.5%
Inpatient - Specialty Hospital	Average Length of Stay	7.0	6.9	-1.7%	19.4	183.0%	178.2%	18.1	-6.4%	160.4%
Ambulatory Surgery Centers - Outpatient Surgeries	Vists per 1,000	65.5	69.4	5.9%	61.7	-11.1%	-5.9%	59.3	-3.8%	-9.5%
Outpatient Hospital - Urgent Care	Vists per 1,000	10.4	15.8	52.2%	18.3	16.2%	76.9%	23.6	29.0%	128.1%
Non-Emergent Transportation - Non-Capitated	Trips per 1,000	31.7	30.0	-5.3%	1,658.7	5,425.9%	5,135.3%	4,962.6	199.2%	15,563.2%

[95] Source: Utilization reports (Report 3) contained within the 2014 – 2016 annual supplemental FIN reports.

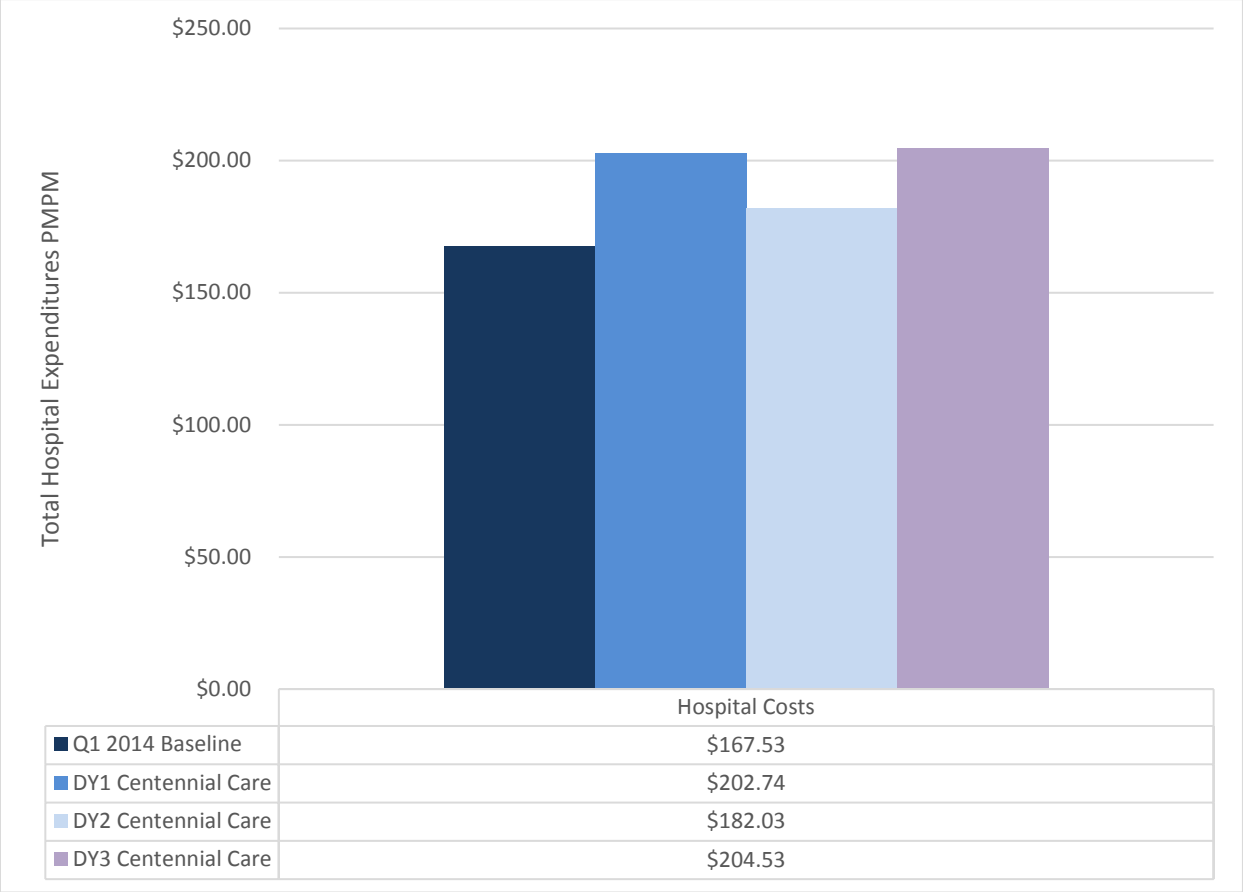
Measure 69 – Hospital costs.

Exhibit 69 presents the PMPM cost for services that are associated with hospital, clinic, and facility visits for DY1, DY2, and DY3 compared to the baseline PMPM. Refer to Appendix A for a complete listing of all services included in this measure. As illustrated, the average PMPM across all hospital services experienced a 10.2% year-over-year decrease in DY2 followed by a 12.4% year-over year increase in DY3, and actual PMPM cost exceed the baseline PMPM in each year.

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

Statistical significance was not calculated for this measure as the aggregate nature of the information was not appropriate for statistical significance testing.

Exhibit 69 – Hospital Cost PMPM[96]



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

[96] Source: Revenue and expense reports (Report 1) contained within the 2014 – 2016 annual supplemental FIN reports.

Measure 70 – Use of HCBS.

Essential to the Centennial Care program is the Community Benefit (CB) home and community-based services (HCBS) program for members who require LTSS to remain in the family residence, in their own home, or in community residences. The CB is a less costly alternative to placement in a Nursing Facility (NF) and is available to members who meet Nursing Facility Level of Care (NF LOC). CB services supplement a member's natural supports but do not provide 24-hour care.

Exhibit 70 presents the annualized utilization for various HCBS services for the Q1 2014 baseline, DY1, DY2, and DY3. From DY2 to DY3, the use of adult day health and assisted living benefits have increased 43.2% and 36.6% respectively, while the use of respite, environmental modifications, and private duty nursing benefits all decreased between 15.7% to 61.5% percent.

Overall from the baseline to DY3, the use of HCBS benefits has increased significantly, with increases in subcategories ranging from 109.4% to 7,929.1%. These HCBS increases are in line with Centennial Care's goal with respect to enhancing services with more effective coordination of care. In addition, the influx of members through the expansion of eligibility may also have had an impact on the calculated increase in utilization. Despite the general trend of increasing utilization, the private duty nursing subcomponent has been consistently experiencing decreases year-over-year, and has decreased 87.4% from the baseline to DY3.

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

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

Exhibit 70 – Use of HCBS[97]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	DY3	Diff. from DY2	Diff. from Baseline
USE OF HOME AND COMMUNITY BASED SERVICES (HCBS)									
Community Benefit - Respite	15 Minute Intervals per 1,000	3,355.9	6,172.0	83.9%	10,955.2	77.5%	7,027.1	-35.9%	109.4%
Community Benefit - Adult Day Health	Days per 1,000	366.3	1,225.1	234.4%	3,233.4	163.9%	4,630.1	43.2%	1,163.9%
Community Benefit - Assisted Living	Days per 1,000	500.9	573.4	14.5%	779.4	35.9%	1,064.7	36.6%	112.6%
Community Benefit - Environmental Modifications	Modifications per 1,000	6.9	20.7	198.7%	660.2	3,089.3%	556.5	-15.7%	7,929.1%
Community Benefit - Private Duty Nursing	15 Minute Intervals per 1,000	853.0	372.9	-56.3%	279.3	-25.1%	107.4	-61.5%	-87.4%

[97] Source: Utilization reports (Report 3) contained within the 2014 – 2016 annual supplemental FIN reports.

Measure 71 – Use of institutional care (skilled nursing facilities).

Exhibit 71 presents the annualized utilization for services related to institutional care for the Q1 2014 baseline, DY1, DY2, and DY3. The days per 1,000 subcomponent increased (105.4%) while the admits per 1,000 subcomponent decreased (-69.7%), resulting in a 578.1% increase in the average length of stay from the baseline to DY3. These increases were consistent with DY2 to DY3 trends for this measure.

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

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

Exhibit 71 – Use of Institutional Care (Skilled Nursing Facilities)[98]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	Diff. from Baseline	DY3	Diff. from DY2	Diff. from Baseline
USE OF INSTITUTIONAL CARE (SKILLED NURSING FACILITY)										
Non-Acute LTC/SNF/Respite	Days per 1,000	76.0	117.4	54.3%	121.9	3.8%	60.3%	156.2	28.1%	105.4%
Non-Acute LTC/SNF/Respite	Admits per 1,000	20.7	29.9	44.3%	6.6	-77.8%	-67.9%	6.3	-5.7%	-69.7%
Non-Acute LTC/SNF/Respite	Average Length of Stay	3.7	3.9	6.9%	18.3	366.8%	399.2%	24.9	35.8%	578.1%

[98] Source: Utilization reports (Report 3) contained within the 2014 – 2016 annual supplemental FIN reports.

Measure 72 – Use of mental health services.

Exhibit 72 presents the annualized utilization for services related to mental health services in the Q1 2014 baseline, DY1, DY2, and DY3. From DY2 to DY3, the utilization of RTCs (-7.9%) and average length of stay for psychiatric hospitalization service (-0.6%) decreased while utilization for foster care therapeutic (47.0%) and Federally Qualified Health Centers (FQHCs) (21.1%) increased. Similar to DY2 to DY3 trends in performance change, the utilization of RTCs (-9.3%) and average length of stay for psychiatric hospitalization service (-12.2%) decreased while utilization for foster care therapeutic (24.4%) and FQHCs (65.8%) increased from the baseline to DY3.

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

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

Exhibit 72 – Use of Mental Health Services[99]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	Diff. from Baseline	DY3	Diff. from DY2	Diff. from Baseline
USE OF MENTAL HEALTH SERVICES										
Residential Treatment Center, ARTC and Group Homes < 21	Days per 1,000	217.1	209.5	-3.5%	213.8	2.1%	-1.5%	197.0	-7.9%	-9.3%
Foster Care Therapeutic (TFC I & II) < 21	Days per 1,000	127.9	129.3	1.1%	108.2	-16.3%	-15.4%	159.1	47.0%	24.4%
Hospital Inpatient Facility (Psychiatric Hospitalization Services)	Days per 1,000	56.6	61.9	9.3%	68.8	11.1%	21.4%	103.1	50.0%	82.1%
Hospital Inpatient Facility (Psychiatric Hospitalization Services)	Admits per 1,000	6.7	7.5	10.9%	9.3	24.0%	37.5%	14.0	50.9%	107.5%
Hospital Inpatient Facility (Psychiatric Hospitalization Services)	Average Length of Stay	8.4	8.3	-1.4%	7.4	-10.4%	-11.7%	7.4	-0.6%	-12.2%
Federally Qualified Health Centers (FQHC's)	Vists per 1,000	147.8	150.1	1.5%	202.3	34.8%	36.8%	245.0	21.1%	65.8%

[99] Source: Utilization reports (Report 3) contained within the 2014 – 2016 annual supplemental FIN reports.

Measure 73 – Use of substance abuse services.

Exhibit 73 presents the annualized utilization for services related to substance abuse in the Q1 2014 baseline, DY1, DY2, and DY3. In the MCO financial reports, methadone treatment was the only category of service determined to be specifically characterized as a substance abuse service, which saw an increase in visits per 1,000 of 35.9% from DY2 to DY3, and a total increase from the baseline to DY3 of 316.8%.

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

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

Exhibit 73 – Use of Substance Abuse Services[100]

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

[100] Source: Utilization reports (Report 3) contained within the 2014 – 2016 annual supplemental FIN reports.

Measure 74 – Use of pharmacy services.

Exhibit 74 presents the annualized utilization for services related to pharmacy in the Q1 2014 baseline, DY1, DY2, and DY3. Generally there were decreases in the number of scripts per 1,000 for brand, generic, and other drugs in the PH, BH, and LTSS care settings from DY2 to DY3, with decreases in the range of 2.8% to 97.6%. The only increases in drug utilization was seen in generic drugs for the PH setting (4.1%) and BH setting (0.9%).

Similar to the DY2 to DY3 timeframe, most drug utilization decreased across BH and LTSS care settings from the baseline to DY3, with decreases in the range of 9.8% to 98.3%. The only increases in scripts per 1,000 were for brand (8.5%) and generic drugs (16.9%) in the PH setting, generic (2.1%) in the BH setting, and other drugs (20.8%) in the LTSS setting.

One item of particular interest was the sharp decrease in the use of "other" type drugs in DY3. We are working with the State to investigate this decrease and determine the reason or identify any potential reporting issue.

When comparing the baseline results to other years, it is important to note that seasonality (the regular and predictable changes which recur every calendar year) may account for some of the difference since the baseline is only the first quarter of 2014. Additionally, although lowering utilization is generally considered a positive outcome, under this measure, higher utilization of generic drugs is desirable as shifting utilization from brand name drugs to generic drugs generally results in a decrease in overall drug costs.

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

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

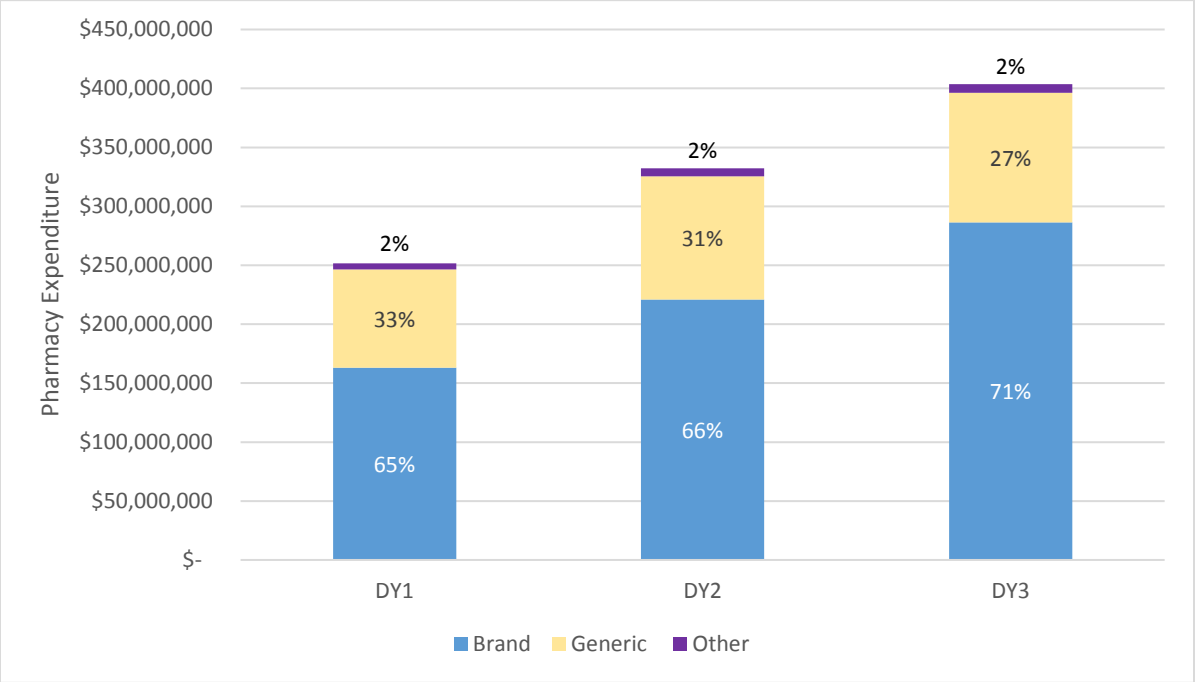
Exhibit 74 – Use of Pharmacy Services[101]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	Diff. from Baseline	DY3	Diff. from DY2	Diff. from Baseline
USE OF PHARMACY										
PHYSICAL HEALTH										
Prescribed Drugs - Brand Name	Scripts per 1,000	842.1	890.8	5.8%	939.4	5.5%	11.6%	913.5	-2.8%	8.5%
Prescribed Drugs - Generic	Scripts per 1,000	5,489.7	5,875.4	7.0%	6,270.9	6.7%	14.2%	6,418.4	2.4%	16.9%
Prescribed Drugs - Other	Scripts per 1,000	180.0	174.2	-3.2%	162.1	-7.0%	-9.9%	24.3	-85.0%	-86.5%
BEHAVIORAL HEALTH										
BH Pharmaceuticals - Brand Name	Scripts per 1,000	183.3	166.9	-9.0%	149.3	-10.5%	-18.6%	141.6	-5.2%	-22.8%
BH Pharmaceuticals - Generic	Scripts per 1,000	1,713.8	1,742.1	1.7%	1,733.5	-0.5%	1.2%	1,749.8	0.9%	2.1%
BH Pharmaceuticals - Other	Scripts per 1,000	71.9	57.0	-20.7%	50.8	-10.9%	-29.4%	1.2	-97.6%	-98.3%
LTSS										
Prescribed Drugs - Brand Name	Scripts per 1,000	1,676.7	1,677.9	0.1%	1,505.5	-10.3%	-10.2%	1,398.3	-7.1%	-16.6%
Prescribed Drugs - Generic	Scripts per 1,000	9,609.5	9,625.5	0.2%	9,237.2	-4.0%	-3.9%	8,666.3	-6.2%	-9.8%
Prescribed Drugs - Other	Scripts per 1,000	358.3	378.0	5.5%	385.2	1.9%	7.5%	432.9	12.4%	20.8%

[101] Source: Utilization reports (Report 3) contained within the 2014 – 2016 annual supplemental FIN reports.

The Evaluation also examined data summarized by Mercer which shows the distribution of pharmacy expenditure in DY1, DY2, and DY3. As illustrated in Exhibit 74, total drug expenditure has been increasing throughout DY1 to DY2, with a 21.4% increase from DY2 to DY3. In addition, pharmacy expenditure has been shifting from generic drugs to brand name drugs from DY1 to DY3. Possible explanations for this shift may include effective but expensive brand name drugs entering the market (such as newly-developed, brand name drugs for Hepatitis C treatment that were utilized mainly by the Medicaid adult expansion group), increases in prices of existing brand name drugs, etc. In DY3, brand name drug expenditure made up 71% of total drug cost, while generic drugs accounted for 27%.

Exhibit 74 – Distribution of Pharmacy Expenditures by Brand, Generic, and Other Drugs[102]



[102] Source: Data summarized by Mercer based on financial statements submitted by MCOs.

Measure 75 – Inpatient services exceeding $50,000.

Exhibit 75 presents the inpatient services exceeding $50,000 as a percentage of total healthcare related expenditures as reported by the MCOs for DY1, DY2, and DY3. The percentage of high cost inpatient service expenditure continues to drop each year from DY1 to DY3, with high cost inpatient claims representing only 1.3% of total healthcare related expenditures in DY3.

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

Statistical significance was not calculated for this measure as the aggregate nature of the information was not appropriate for statistical significance testing.

Exhibit 75 – Inpatient Services Exceeding $50,000 as % of Total Healthcare Expenditures[103]

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

[103] Source: Revenue and expense reports and high cost claims reports (Report 1 and Report 7) contained within the 2014 – 2016 annual supplemental FIN reports.

Measure 76 – Diagnostic imaging costs.

Exhibit 76 presents the PMPM cost for services related to diagnostic imaging for the Q1 2014 baseline, DY1, DY2, and DY3. Although the PMPM cost of diagnostic imaging service dropped below the baseline in DY2, it increased substantially in DY3 and exceeded the baseline by 21.7%.

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

Statistical significance was not calculated for this measure as the aggregate nature of the information was not appropriate for statistical significance testing.

Exhibit 76 – Diagnostic Imaging Cost PMPM[104]

	Q1 2014	DY1	DY2	DY3
Baseline	$0.67	$0.67	$0.67	$0.67
Measured Total	$0.67	$0.71	$0.49	$0.82
Measured Over/(Under) Baseline	$0.00	$0.04	-$0.19	$0.15
% Measured Over/(Under) Baseline	0.0%	5.5%	-28.0%	21.7%

[104] Source: Expense reports (Report 2) contained within the 2014 – 2016 annual supplemental FIN reports.

Measure 77 – Emergency department use.

Exhibit 77 presents ER utilization for the Q1 2014 baseline, DY1, DY2, and DY3. As the exhibit illustrates, utilization for ER services increased in both PH and LTSS care settings from the baseline to DY3, which is an undesirable trend given that ER services are high cost in nature. However, it is important to note that ER utilization has been experiencing annual decreases from DY1 to DY3 in the PH care setting, which serves a population base that is more than twelve times larger than the population served in the LTSS care setting.

It is likely that the membership change in the adult expansion group had an impact on the results for this measure since this measure is inclusive of all populations and not limited to a specific population subset or MEG.

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

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

Exhibit 77 – Emergency Department Use[105]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	Diff. from Baseline	DY3	Diff. from DY2	Diff. from Baseline
EMERGENCY DEPARTMENT USE										
PHYSICAL HEALTH										
Outpatient Hospital - Emergency Room	Vists per 1,000	552.5	579.0	4.8%	557.8	-3.7%	1.0%	556.2	-0.3%	0.7%
LTSS										
Outpatient Hospital - Emergency Room	Vists per 1,000	552.6	599.8	8.5%	690.8	15.2%	25.0%	734.9	6.4%	33.0%

[105] Source: Utilization reports (Report 3) contained within the 2014 – 2016 annual supplemental FIN reports. In 2016, the "Ambulance – Ground" category of service was removed from PH and Other Adult Group – Physical Health (OAGPH) reports, therefore analysis for this measure no longer includes ambulance services.

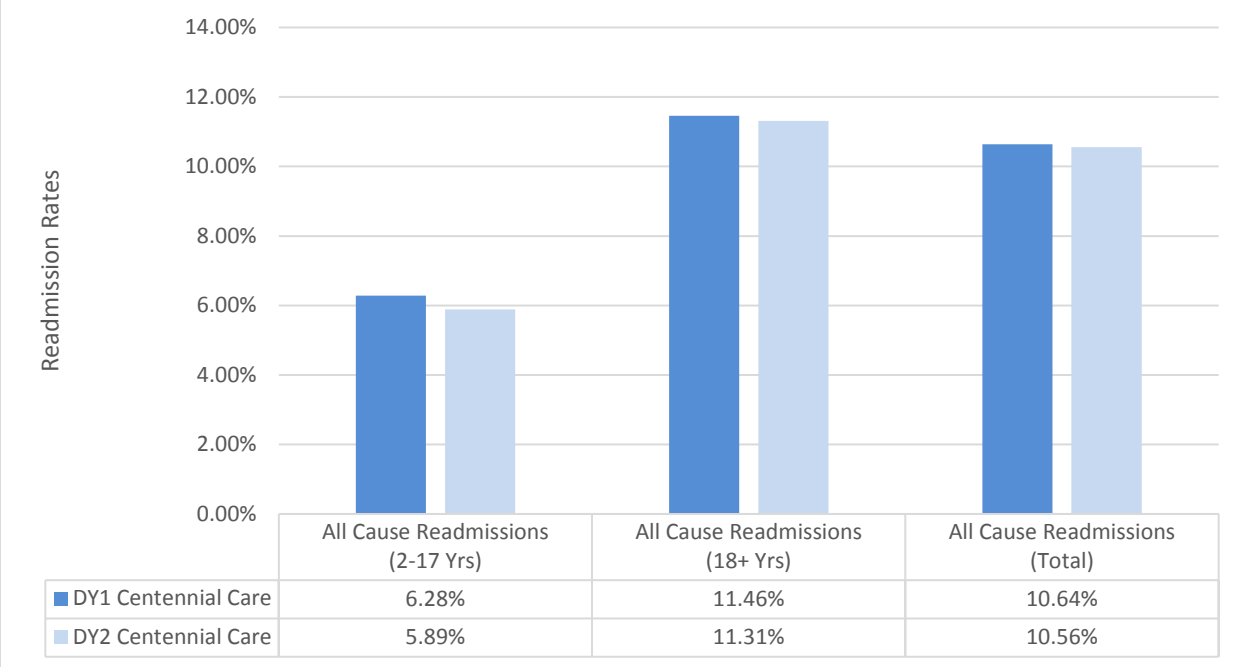
Measure 78 – All cause readmissions.

Exhibit 78 presents readmission rates for the 2-17 years of age cohort, 18+ years of age cohort, and the weighted average of both cohorts in DY1 and DY2. As illustrated, all cause readmission rates decreased for both the 2-17 years of age cohort (-6.2%) and the 18+ years of age cohort (-1.3%), which resulted in a 0.8% decrease in the weighted average readmission rate from DY1 to DY2. It should be noted that since the 18+ years of age cohort is roughly ten times larger than the 2-17 years of age cohort, the aggregate readmission rate is weighted more heavily toward the rate of the 18+ years of age cohort.

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

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

Exhibit 78 – All Cause Readmission Rate[106]



	All Cause Readmissions (2-17 Yrs)	All Cause Readmissions (18+ Yrs)	All Cause Readmissions (Total)
DY1 Centennial Care	6.28%	11.46%	10.64%
DY2 Centennial Care	5.89%	11.31%	10.56%

[106] Source: Data provided by Mercer. HSD indicated a data source change for this measure in DY2 to replace MMIS data with Mercer summary data. Due to the change in available fields in the new reports, there is a change in the subcomponents analyzed for this measure compared to the DY1 Annual Report.

Measure 79 – Inpatient mental health/substance use services.

Exhibit 79 presents the utilization for services related to inpatient mental health and substance abuse for the Q1 2014 baseline, DY1, and DY2. The utilization of psychiatric hospitals stayed relatively consistent throughout the baseline to DY2, at around 1.3 encounters per client. There was a slight decrease (-28.0%) in utilization of RTCs from DY1 to DY2, but an overall significant increase (683.6%) from the baseline to DY2.

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

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

Exhibit 79 – Inpatient Mental Health/Substance Use[107]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	Diff. from Baseline
INPATIENT MENTAL HEALTH/SUBSTANCE ABUSE SERVICES							
Psychiatric Hospital	Encounters per Client	1.28	1.27	-1.4%	1.30	2.5%	1.1%
Residential Treatment Center	Encounters per Client	1.04	11.33	987.9%	8.16	-28.0%	683.6%

[107] Source: Inpatient mental health and substance use MMIS reports.

Research Question 3.B

Has the member rewards program encouraged members to better manage their care?

The Centennial Rewards program is an incentive program that went live on April 1, 2014 as part of Centennial Care and is designed to motivate members to better manage their own health. For example, members can earn rewards for adhering to medication regiments and routine exams for various chronic illnesses or behavioral conditions such as refilling prescriptions for asthma, schizophrenia, bipolar and taking medical exams for diabetes. To increase program awareness and engagement, MCOs have been actively involved in outreach, communication, and marketing, including distributing program materials and reaching out to members through the call center. There is also a public portal that allows individuals not registered for the program to learn more about Centennial Rewards.

The Evaluation is reviewing the impact of the Centennial Rewards program on member behavior through analysis of nine measures designed to monitor members' compliance with various treatment protocols or use of annual preventive services. Currently, performance measures are not reported for Centennial Rewards enrollees by specific cohorts. For the purposes of this report, the reward-earning and redemption rates associated with the health compliance activities were examined in detail for the population as a whole.

Overall through DY2 of the Centennial Care program, all measures experienced significant increases in members earning rewards and redemption rates. This includes increases in members earning and redeeming rewards for managing chronic conditions such as asthma, schizophrenia, bipolar disorder, and diabetes. There were also increases in members earning and redeeming rewards for engaging in preventive services such as receiving an annual bone density test for those at risk for osteoporosis, pregnant women enrolling in prenatal programs, and child and adult members receiving an annual dental visit.

These results indicate that the Centennial Rewards program has encouraged members to engage in the program and better manage their own health and wellness.

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

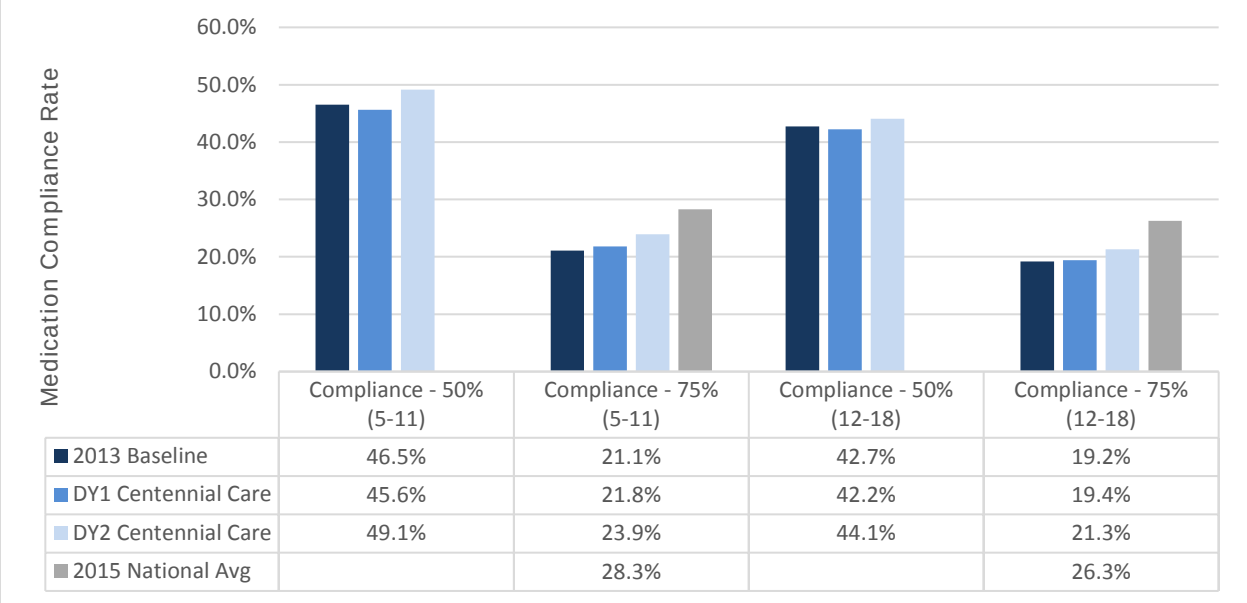
Measure 80 – Asthma controller medication compliance (children).

Exhibit 80.a demonstrates asthma medication compliance for children at various compliance levels and age cohorts. The compliance rates are shown for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average.

Aggregate compliance rates increased from DY1 to DY2 for all compliance thresholds and age cohorts, but the only statistically significant change was the 7.7% increase of the 50% compliance rate for the 5-11 years of age cohort. Upon review of individual MCO performance, PHP was the only MCO that experienced statistically significant changes from DY1 to DY2, with 17.4% to 34.8% increases across all age cohorts.

Aggregate compliance rates increased from the baseline to DY2 for all thresholds and cohorts, but the only statistically significant rate of change was a 13.6% increase of the 75% compliance rate for the 5-11 years of age cohort. The compliance rates at the 75% threshold show slight positive trends year-over-year but remained below the 2015 national average. PHP was the only MCO that experienced statistically significant changes from the baseline to DY2, with increases ranging between 11.5% and 30.2% across all subcomponents.

Exhibit 80.a – Asthma Medication Compliance for Children[108]



	Compliance - 50% (5-11)	Compliance - 75% (5-11)	Compliance - 50% (12-18)	Compliance - 75% (12-18)
2013 Baseline	46.5%	21.1%	42.7%	19.2%
DY1 Centennial Care	45.6%	21.8%	42.2%	19.4%
DY2 Centennial Care	49.1%	23.9%	44.1%	21.3%
2015 National Avg		28.3%		26.3%

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

Exhibit 80.b summarizes activity of members earning and redeeming Centennial Rewards points for activities to manage their children's asthma condition. As indicated in the exhibit, the number of members earning rewards and the percentage of members that are redeeming their rewards has increased substantially from DY1 to DY2. This may suggest the Centennial Rewards program incentivizes greater compliance for those registered and active in the program compared to the broader Centennial Care population.

Exhibit 80.b Centennial Rewards for Activities Related to Asthma in Children, DY1 – DY2[109]

		Cumulative DY1		Cumulative DY1-DY2		% Change	
Activity Group	Activity	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	% Change in Members Earning Rewards	% Change in Redemption Rates
Asthma	1st Asthma	6,274	9.1%	11,152	29.1%	77.7%	218.9%
Asthma	3rd Asthma	4,771	8.6%	8,198	30.4%	71.8%	252.6%
Asthma	6th Asthma	2,510	7.5%	4,139	33.1%	64.9%	340.2%
Asthma	9th Asthma	1,246	5.9%	2,260	33.8%	81.4%	476.3%
Asthma	12th Asthma	663	5.7%	1,252	35.3%	88.8%	516.0%

[109] Source: Finity 2015 member rewards data.

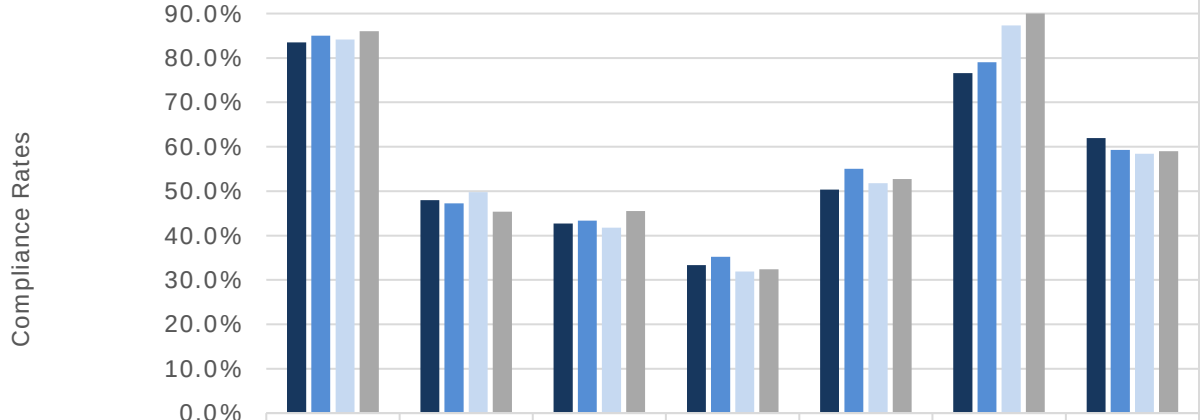
Measure 81 – Diabetes - annual recommended tests (A1C, LDL, eye exam, nephropathy exam.

Exhibit 81.a demonstrates compliance rates for various preventive services associated with diabetes care and monitoring. The compliance rates are shown for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average.

Nephropathy was the only subcomponent that showed increased compliance (10.4% increase) from DY1 to DY2, which was statistically significant at the 95% confidence level. Of the subcomponents that showed decreases, eye exam was the only statistically significant change with a decrease of 5.9%. Note that while the rate for HbA1c poor control subcomponent increased from DY1 to DY2, it is an inverse measure, meaning a decrease in the rate indicates improved compliance and vice versa.

The baseline to DY2 rate of change for nephropathy was 14.0% and the baseline to DY2 rate of change for blood pressure control was -5.7%, which were the only statistically significant rates of change between the baseline and DY2. Of the non-statistically significant rates of change, HbA1C testing and eye exams rates increased, while HbA1c control (<8.0% and <7.0%) rates decreased, and HbA1c poor control experienced an unfavorable increase from the baseline to DY2.

Exhibit 81.a – Comprehensive Diabetes Care[110]



	HbA1c Testing	HbA1c Poor Control	HbA1c Control (<8.0%)	HbA1c Control (<7.0%)	Eye Exam	Nephropathy	Blood Pressure
2013 Baseline	83.5%	47.9%	42.7%	33.3%	50.4%	76.6%	62.0%
DY1 Centennial Care	85.0%	47.2%	43.4%	35.2%	55.0%	79.1%	59.3%
DY2 Centennial Care	84.1%	49.8%	41.8%	31.9%	51.8%	87.3%	58.4%
2015 National Avg	86.0%	45.4%	45.5%	32.4%	52.7%	90.0%	59.0%

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

Exhibit 81.b summarizes activity on members earning and redeeming Centennial Rewards points for activities to manage their diabetes. As seen in the table, the number of members earning rewards and the percentage of members redeeming rewards has increased substantially from DY1 to DY2. This may suggest the Centennial Rewards program incentivizes greater compliance for those registered and active in the program compared to the broader Centennial Care population.

Exhibit 81.b Centennial Rewards for Activities Related to Diabetes, DY1 – DY2[111]

		Cumulative DY1		Cumulative DY1-DY2		% Change	
Activity Group	Activity	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	% Change in Members Earning Rewards	% Change in Redemption Rates
Diabetes	Eye Exam	9,874	8.0%	21,951	24.1%	122.3%	203.5%
Diabetes	HbA1c Test	18,135	9.2%	28,723	25.9%	58.4%	180.9%
Diabetes	LDL Test	13,569	9.2%	23,617	26.7%	74.1%	190.8%
Diabetes	Nephropathy Exam	14,944	9.0%	28,072	24.2%	87.8%	168.2%

[111] Source: Finity 2015 member rewards data.

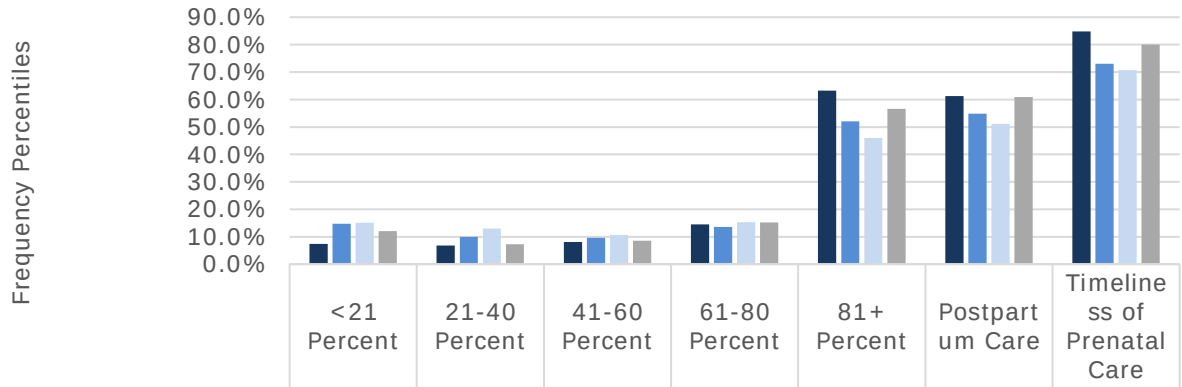
Measure 82 – Prenatal program.

Exhibit 82.a demonstrates compliance rates of frequency for ongoing prenatal care, postpartum care, and timeliness of prenatal care. The compliance rates are shown for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average.

Three subcomponents had statistically significant rates of change from DY1 to DY2. The percentage of deliveries that received 21-40% of expected visits increased 30.5%, and the percentage of deliveries that received over 81% of expected prenatal visits decreased 11.8%. The percentage of deliveries that received postpartum care decreased 6.7%. Three subcomponents experienced increase in rates but are not statistically significant: deliveries that received under 21%, between 41-60%, and between 61-80% expected visits. Timeliness of prenatal care rates decreased from DY1 to DY2 although not statistically significant.

From the baseline to DY2, lower frequencies of prenatal visits increased across compliance categories (deliveries receiving under 21% expected visits increased 104.9%, deliveries receiving 21-40% expected visits increased 89.5%, deliveries receiving 41-60% expected visits increased 32.2%, deliveries receiving 61-80% expected visits increased 5.7%), while the percentage of deliveries that received over 81% of expected prenatal visits decreased 27.3%. The percentage of deliveries that received postpartum care decreased 16.5%, and the timeliness of prenatal care decreased 16.6% from the baseline to DY2. All changes from the baseline to DY2 were statistically significant at the 95% confidence level except for rates of deliveries receiving 61-80% expected prenatal visits. Most subcomponents of the prenatal program measure underperformed compared to the 2015 national average rates in DY2.

Exhibit 82.a – Prenatal Program[112]



	<21 Percent	21-40 Percent	41-60 Percent	61-80 Percent	81+ Percent	Postpartum Care	Timeliness of Prenatal Care
2013 Baseline	7.4%	6.8%	8.1%	14.5%	63.2%	61.3%	84.8%
DY1 Centennial Care	14.8%	9.9%	9.6%	13.6%	52.1%	54.8%	73.0%
DY2 Centennial Care	15.1%	13.0%	10.6%	15.3%	45.9%	51.2%	70.7%
2015 National Avg	12.0%	7.3%	8.6%	15.2%	56.6%	60.9%	80.0%

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

Exhibit 82.b summarizes activity on members earning and redeeming Centennial Rewards points for activities to enroll in the prenatal program. As seen in the exhibit, the number of members earning rewards and the percentage of members redeeming rewards has increased substantially from DY1 to DY2. This may suggest the Centennial Rewards program incentivizes greater compliance for those registered and active in the program compared to the broader Centennial Care population.

Exhibit 82.b – Centennial Rewards for Activities Related to Prenatal Program, DY1 – DY2[113]

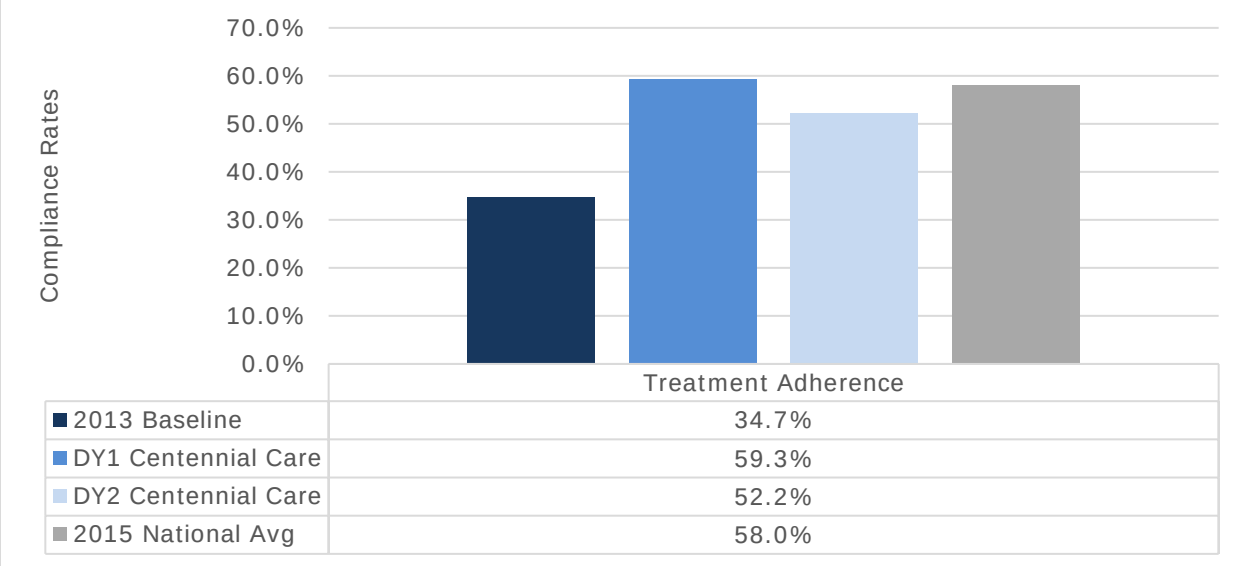
		Cumulative DY1		Cumulative DY1-DY2		% Change	
Activity Group	Activity	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	% Change in Members Earning Rewards	% Change in Redemption Rates
Pregnancy	Prenatal Enrollment	3,441	10.8%	7,386	24.0%	114.6%	122.4%

[113] Source: Finity 2015 member rewards data.

Measure 83 – Treatment adherence – schizophrenia.

Exhibit 83.a presents the schizophrenia treatment adherence rate for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average. Although the treatment adherence rate experienced a statistically significant decline of 12.0% from DY1 to DY2, the aggregate change from the baseline to DY2 was a statistically significant increase of 50.3%. This increase from the baseline to DY2 was mainly driven by PHP's increase of 135.4%, which was the only statistically significant change among all MCOs. The DY2 performance was below the national average rate for 2015.

Exhibit 83.a – Treatment Adherence – Schizophrenia[114]



	Treatment Adherence
2013 Baseline	34.7%
DY1 Centennial Care	59.3%
DY2 Centennial Care	52.2%
2015 National Avg	58.0%

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

Exhibit 83.b summarizes activity on members earning and redeeming Centennial Rewards points for activities to manage schizophrenia. As seen in the exhibit, the number of members earning rewards and the percentage of members redeeming rewards have increased substantially from DY1 to DY2. This may suggest the Centennial Rewards program encourages greater treatment adherence for the subset of Centennial Care members that are registered for the Centennial Rewards program compared to the broader Centennial Care population.

Exhibit 83.b – Centennial Rewards for Activities Related to Schizophrenia, DY1 – DY2[115]

		Cumulative DY1		Cumulative DY1-DY2		% Change	
Activity Group	Activity	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	% Change in Members Earning Rewards	% Change in Redemption Rates
Schizophrenia	1st Schizophrenia	3,083	6.8%	4,718	19.9%	53.0%	190.8%
Schizophrenia	3rd Schizophrenia	2,515	6.7%	3,888	21.0%	54.6%	213.8%
Schizophrenia	6th Schizophrenia	1,944	6.0%	3,038	22.0%	56.3%	268.5%
Schizophrenia	9th Schizophrenia	1,570	5.2%	2,460	22.4%	56.7%	328.8%
Schizophrenia	12th Schizophrenia	1,100	5.2%	1,885	22.2%	71.4%	327.9%

[115] Source: Finity 2015 member rewards data.

Measure 85 – Osteoporosis management in elderly women - females aged 65+ years.

Exhibit 85.a presents data on osteoporosis management in elderly women for the 2013 baseline, DY1, DY2, and DY3. The number of unique clients and unique encounters both increased significantly from the baseline to DY3. However, the more relevant subcomponent is the number of unique encounters per client, which decreased by 2.0% from the baseline to DY3.

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

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

Exhibit 85.a – Osteoporosis Management in Elderly Women – Females Age 65+ Years[116]

Program Measure	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	DY3	Diff. from DY2	Diff. from Baseline
Unique Count of Clients	106	159	50.0%	227	42.8%	253	11.5%	138.7%
Unique Count of Encounter Claims	127	195	53.5%	271	39.0%	297	9.6%	133.9%
Unique Count of Encounter Per Client	1.20	1.23	2.4%	1.19	-2.7%	1.17	-1.7%	-2.0%

Exhibit 85.b summarizes activity on members earning and redeeming Centennial Rewards points for bone density testing. As seen in the exhibit, the number of members earning rewards and the percentage of members redeeming rewards have increased substantially from DY1 to DY2. This may suggest the Centennial Rewards program incentivizes greater compliance for those registered and active in the program compared to the broader Centennial Care population.

Exhibit 85.b – Centennial Rewards for Bone Density Testing, DY1 – DY2[117]

		Cumulative DY1		Cumulative DY1-DY2		% Change	
Activity Group	Activity	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	% Change in Members Earning Rewards	% Change in Redemption Rates
Bone Density	Bone Density Test	374	5.1%	749	20.3%	100.3%	299.5%

[116] Source: Osteoporosis MMIS Report.
[117] Source: Finity 2015 member rewards data.

Measure 86 – Annual dental visit – adult.

Exhibit 86.a illustrates frequency of dental visits among members 19-21 years of age for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average. The percentage of young adults receiving at least one dental visit annually had an increase of 15.9% from DY1 to DY2, although there has been a decrease of 9.0% from the baseline to DY2. Both rates of change are statistically significant. It is important to note that DY2 performance exceeded the HEDIS Medicaid national average.

Exhibit 86.a – Annual Dental Visit – Adult[118]

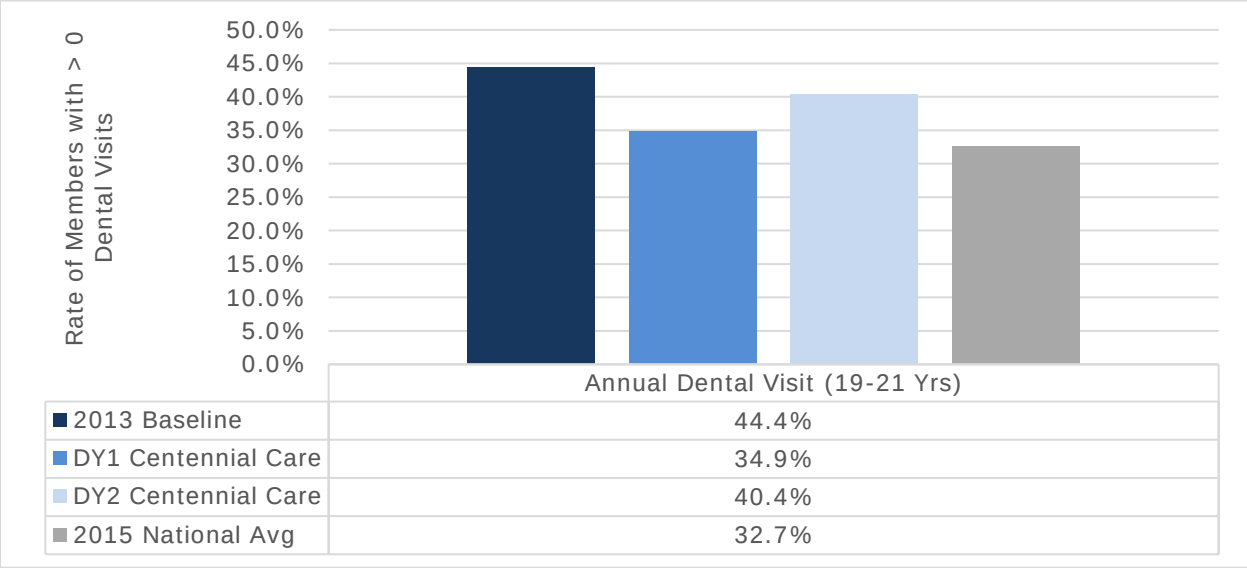


Exhibit 86.b summarizes activity on members earning and redeeming Centennial Rewards points for having their annual dental visit. As seen in the exhibit, the number of members earning rewards and the percentage of members redeeming rewards have increased substantially from DY1 to DY2, which may suggest the Centennial Rewards program incentivizes greater compliance for those registered and active in the program compared to the broader Centennial Care population.

Exhibit 86.b – Centennial Rewards for Adult Annual Dental Visits, DY1 – DY2[119]

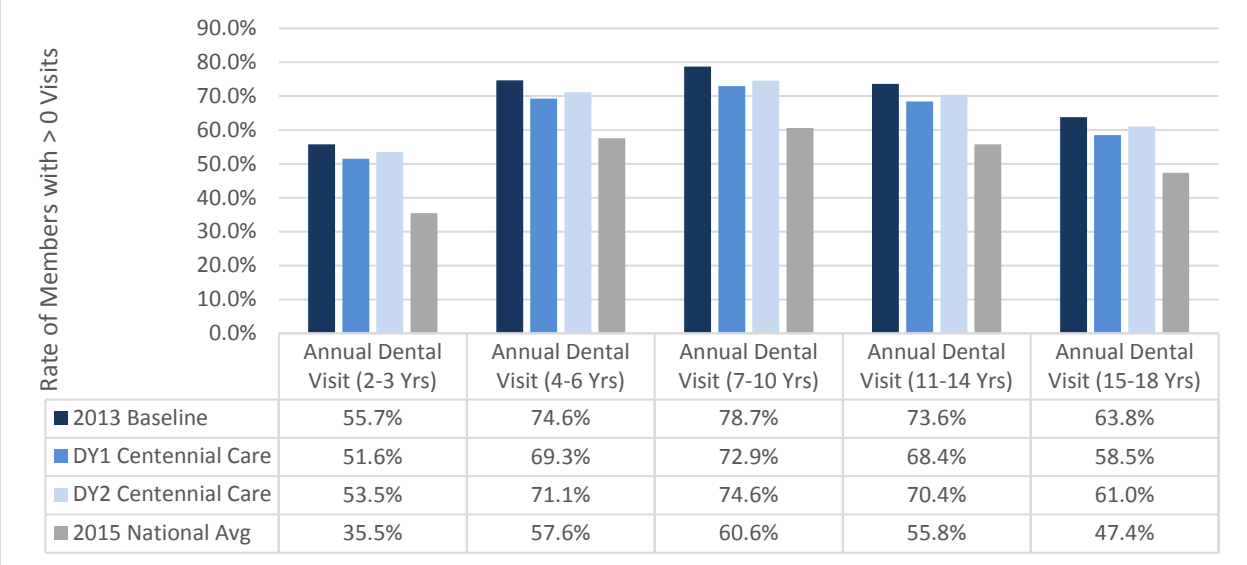
		Cumulative DY1		Cumulative DY1-DY2		% Change	
Activity Group	Activity	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	% Change in Members Earning Rewards	% Change in Redemption Rates
Dental	Adult Dental Visit	82,646	7.4%	152,833	19.7%	84.9%	164.4%

[118] Source: MCO annual HEDIS reports for 2013 – 2015.
[119] Source: Finity 2015 member rewards data.

Measure 87 – Annual dental visit – child.

Exhibit 87.a illustrates frequency of dental visits among children up to age 18 for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average. The percentage of children receiving at least one dental visit annually increased in the range of 2.3% to 4.4% across all age cohorts from DY1 to DY2, although the rates decreased in the range of 4.0% to 5.2% across all age cohorts from the baseline to DY2. All rates of change are statistically significant at the 95% confidence level. It is important to note that DY2 performance exceeded the HEDIS Medicaid national average across all age cohorts.

Exhibit 87.a – Annual Dental Visit – Child[120]



	Annual Dental Visit (2-3 Yrs)	Annual Dental Visit (4-6 Yrs)	Annual Dental Visit (7-10 Yrs)	Annual Dental Visit (11-14 Yrs)	Annual Dental Visit (15-18 Yrs)
2013 Baseline	55.7%	74.6%	78.7%	73.6%	63.8%
DY1 Centennial Care	51.6%	69.3%	72.9%	68.4%	58.5%
DY2 Centennial Care	53.5%	71.1%	74.6%	70.4%	61.0%
2015 National Avg	35.5%	57.6%	60.6%	55.8%	47.4%

Exhibit 87.b summarizes members earning and redeeming Centennial Rewards points for activities performed to manage their children's dental health. As seen in the exhibit, the number of members earning rewards and the percentage of members redeeming rewards has increased substantially from DY1 to DY2. This may suggest the Centennial Rewards program incentivizes greater compliance for those registered and active in the program compared to the broader Centennial Care population.

Exhibit 87.b – Centennial Rewards for Child Annual Dental Visits, DY1 – DY2[121]

		Cumulative DY1		Cumulative DY1-DY2		% Change	
Activity Group	Activity	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	% Change in Members Earning Rewards	% Change in Redemption Rates
Dental	Child Dental Visit	157,152	8.9%	214,036	25.7%	36.2%	188.5%

[120] Source: MCO annual HEDIS reports for 2013 – 2015.
[121] Source: Finity 2015 member rewards data.

Measure 88 – Number of members spending credits.

Exhibit 88 summarizes the number of members spending credits in DY1 and DY2. As illustrated in the exhibit, the number of members registered, earning, and redeeming rewards all increased significantly from DY1 to DY2. More importantly, a larger percentage of members that are earning rewards are redeeming rewards in DY2 (20.0%) compared to DY1 (8.4%).

Exhibit 88 – Number of Members Spending Credits[122]

Measure	DY1	DY2
Number of Members Registered in the Rewards Program	46,537	155,764
Number of Members Earning Rewards	263,336	502,448
Number of Members Redeeming Rewards	22,150	100,579
Percentage of Members Redeeming Rewards	8.4%	20.0%

[122] Source: Finity 2015 member rewards data.

Hypothesis 4

Streamlining through Centennial Care will result in improved health care experiences for beneficiaries, improved claims processing for providers, and efficiencies in program administration for the state.

Centennial Care supports improved healthcare delivery and emphasizes greater access to primary care services. Access to primary care is important for preventive care and management of existing conditions because primary care may allow for members to increase use of preventive services and care management for existing conditions. Centennial Care seeks to enhance the access and availability of primary care to address existing care needs and prevent more serious conditions.

The Evaluation found that results of the Centennial Care program have been mixed, producing some improved outcomes and some that have declined since the implementation of the program. These outcomes vary among populations surveyed for individuals measured.

Research Question 4.A

Are enrollees satisfied with their providers and the services they receive?

The Centennial Care waiver consolidates services within a single program and defines performance standards for contracted MCOs related to timely adjudication of member grievances and appeals, access to providers, and responsive customer service. These performance standards are intended, in part, to improve the member experience and increase satisfaction with the program.

The Evaluation is reviewing Centennial Care's impact on member satisfaction through the analysis of 12 measures that address grievance and appeal resolution timeliness and components of member satisfaction. For each measure, performance is tracked over time against a baseline value as well as on an annual basis.

Overall through DY2 of the Centennial Care program, programmatic performance was generally positive from the member's perspective. Member satisfaction rates and grievances/appeals performance metrics reported showed improvement in 7 out of 12 measures. Improved performance was experienced in the percentage of expedited appeals resolved on time; and the percentage of appeals upheld, partially overturned, and overturned. There were also improvements across all three cohorts for the number and percentage of members satisfied with their care coordination, slight improvements for two of three subcomponents for the rating of personal doctors, and improvements across all three cohorts for customer service.

Measure performance remained relatively consistent through DY2 for the percentage of grievances resolved within 30 days and the number and percentage of calls answered within 30 seconds, both of which maintained high rates each year.

Opportunities for continued improvement were identified for the remaining three measures: rating of health care, which experienced slight decreases in two of three cohorts; rating for how well doctors communicate, which also experienced decreases in two of three cohorts; and the rating for the specialist seen most often, which decreased for two of three cohorts.

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

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

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

Exhibit 88 presents the rate at which expedited appeals were resolved within their allowed timeframes for DY1 and DY2. The overall resolution rate increased by 0.6% from DY1 to DY2.

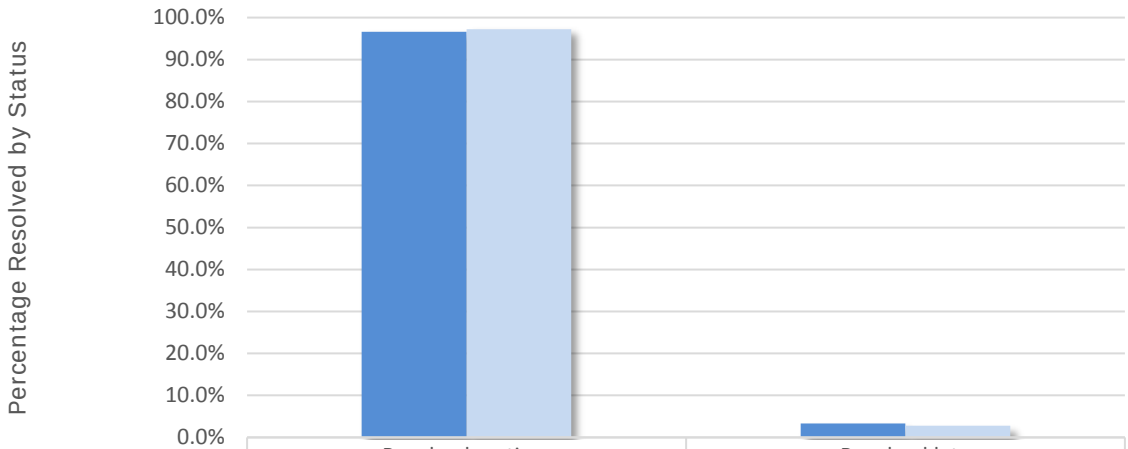
When analyzing changes from DY1 to DY2 among individual MCOs, PHP experienced the greatest increase (4.3%) followed by UHC (2.1%), while BCBS (-4.4%) and MHC (-0.9%) both experienced declines.

Emerging data through November of DY3 suggests that the rate at which expedited appeals were resolved within their allowed timeframe may decline slightly from DY2 to DY3, however it should be noted that the overall resolution rates across all three demonstration years are very high.

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

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

Exhibit 88 – Percent of Expedited Appeals Resolved on Time[123]



	Resolved on time	Resolved late
DY1 Centennial Care	96.7%	3.3%
DY2 Centennial Care	97.2%	2.8%

[123] Source: MCO reports for 2014 – 2015 (HSD 37).

Measure 89 – Percentage of grievances resolved within 30 days.

Exhibit 89 presents the rate at which grievances were resolved within 30 days for DY1 and DY2. The overall resolution rate increased slightly by 0.1% from DY1 to DY2.

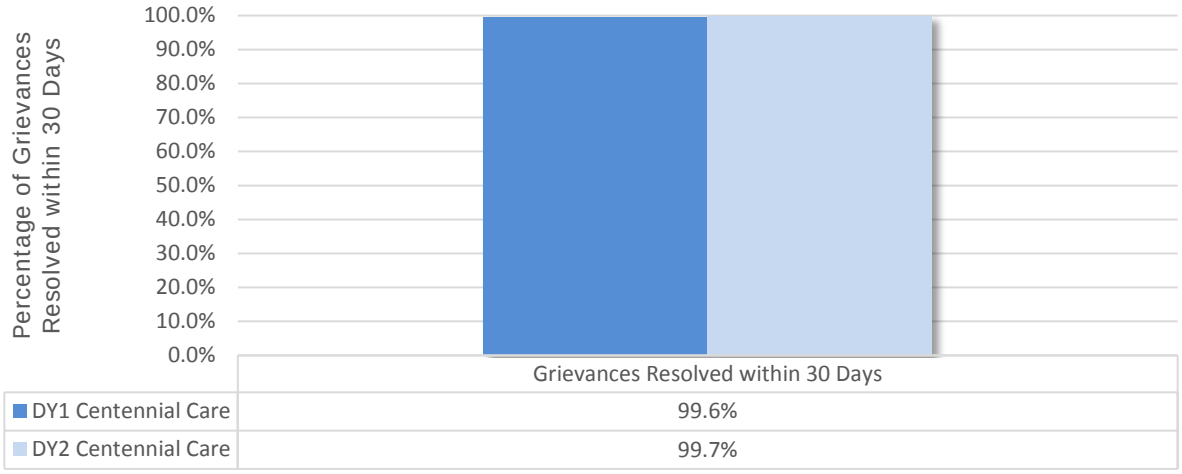
Among individual MCOs, BCBS experienced a 1.2% increase, and PHP's rate did not change from DY1 to DY2; MHC and UHC experienced declines in their rates over the same period of 0.1% and 0.4% respectively.

Emerging data through November of DY3 suggests that the rate at which grievances were resolved within 30 days may decline slightly from DY2 to DY3, however it should be noted that the overall resolution rates across all three demonstration years are very high.

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

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

Exhibit 89 – Percentage of Grievances Resolved on Time[124]



[124] Source: MCO reports for 2014 – 2015 (HSD 37).

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

Exhibit 90 presents the rate at which appeals were upheld, partially overturned, or overturned. The rate at which appeals were upheld declined 6.4% from DY1 to DY2, while the rate at which appeals were partially overturned and fully overturned decreased over the same period by 45.4% and 11.0%, respectively.

Three of four MCOs experienced an increase in upheld appeals, a development that reflects positively on the adjudication of appeals under Centennial Care. The largest relative increase among MCOs was a 25.7% increase experienced by UHC. The other changes among BCBS, MHC, and PHP were -3.8%, 2.6%, and 3.4%, respectively.

BCBS, PHP, and UHC experienced decreases in the percentage of appeals that were partially overturned, which is also considered a positive development. MHC's rate did not change from DY1 to DY2.

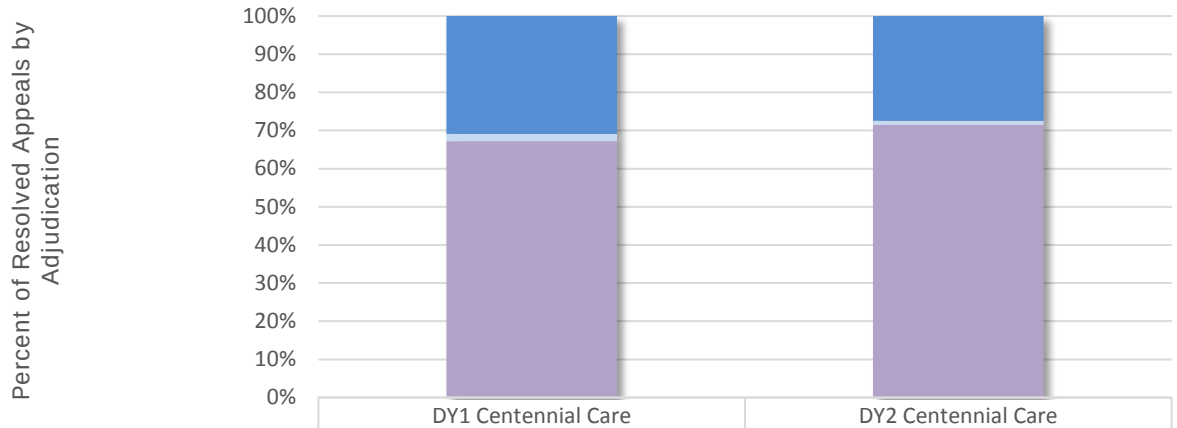
For the percentage of appeals fully overturned, MHC, PHP, and UHC each experienced a decline in the rate from DY1 to DY2, which is a positive development. BCBS experienced a slight increase over the same period.

Emerging data through November of DY3 suggests that Centennial Care may see a slight decline from DY2 to DY3 in appeals upheld and appeals partially overturned, and an increase in the percentage of appeals fully overturned.

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

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

Exhibit 90 – Appeals by Adjudication[125]



	DY1 Centennial Care	DY2 Centennial Care
Appeals overturned	30.9%	27.5%
Appeals partially overturned	1.9%	1.0%
Appeals upheld	67.2%	71.5%

[125] Source: MCO reports for 2014 – 2015 (HSD 37).

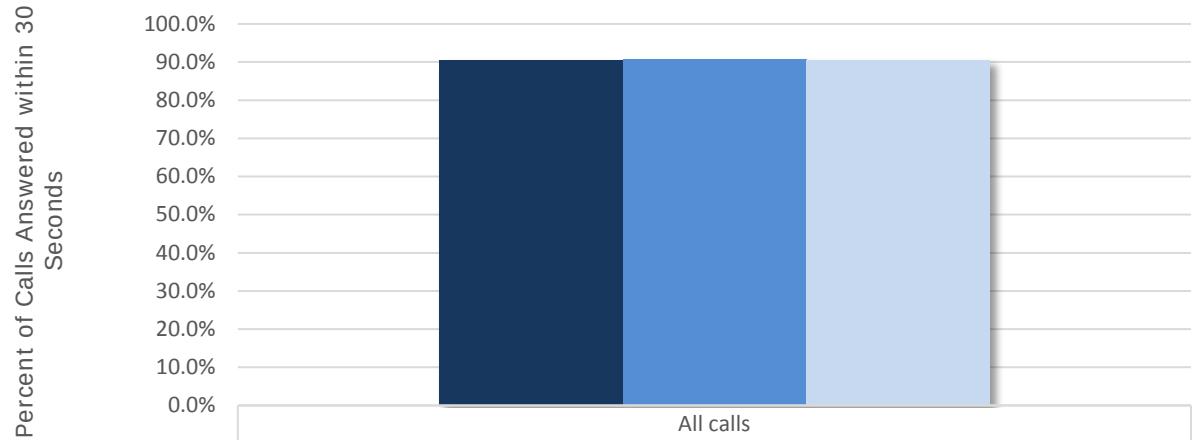
Measure 93 – Number and percentage of calls answered within 30 seconds.

Exhibit 93 presents rates for the 2013 baseline, DY1, and DY2 for the percentage of calls answered within 30 seconds. The percentage of calls answered within 30 seconds declined slightly from DY1 to DY2 by 0.3%, a change that was not statistically significant at a 95% confidence level. Overall, the rate declined slightly from the baseline to DY2 by 0.2%, which was not statistically significant at the 95% confidence level.

Only two MCOs, PHP and UHC, had a reportable rate in DY2, compared to all four having a reportable rate in DY1. Both rates improved from DY1 to DY2. UHC's increase (2.4%) was relatively larger than PHP's increase (0.3%), and both increases were statistically significant at the 95% confidence level. Both plans' increases from the baseline to DY2 were also statistically significant, and UHC's increase (1.9%) was greater than that of PHP (1.4%).

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

Exhibit 93 –Percentage of Calls Answered within 30 Seconds[126]



[126] Source: MCO Annual HEDIS Reports for 2013 – 2015.

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

Exhibit 94 presents percentages for the 2013 baseline, DY1, DY2, and an appropriate national average comparison rate for the percentage of participants satisfied with their care coordination. This information is based on CAHPS surveys that are sent out to random samples of eligible members covered under each MCO. Results of the survey are segmented into three population subgroups, the adult group, the child group ("child general population"), and children with chronic conditions (CCC).

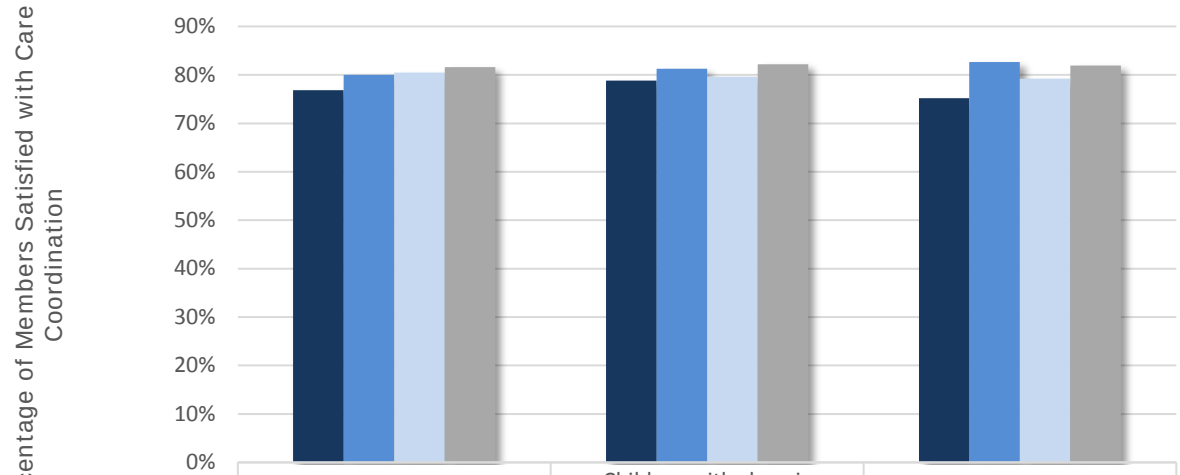
As illustrated, the percentage for the adult population in increased between DY1 and DY2 (1%), though declines were experienced among children with chronic conditions (-2%) and the child general population (-4%) during the same period.

All three population subgroups have experienced increases from the baseline to DY2 in the percentage of members that expressed satisfaction with their care coordination. The adult population has increased 5%, children with chronic conditions has increased 1%, and the child general population has increased 5% from the baseline to DY2.

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

For a national average Deloitte used the SPH Analytics benchmark percentage for the adult and child general populations. For the children with chronic conditions population, Deloitte used the QC All Plans benchmark rate as the SPH Analytics benchmark was not available.

Exhibit 94 –Percentage of Participants Satisfied with Care Coordination[127]



	Adult	Children with chronic conditions	Child general population
2013 Baseline	77%	79%	75%
DY1 Centennial Care	80%	81%	83%
DY2 Centennial Care	81%	80%	79%
2015 National Avg	82%	82%	82%

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

Measure 95 – Rating of personal doctor.

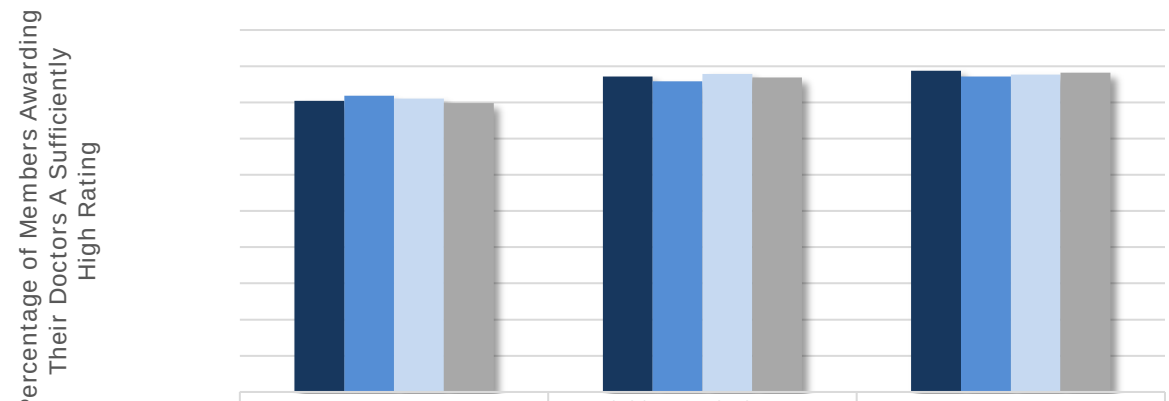
Exhibit 95 presents percentages for the 2013 baseline, DY1, DY2 and an appropriate national average for the percentage of participants satisfied with their personal doctor. As illustrated, the satisfaction percentage increased for two of three populations between DY1 and DY2, namely the child general population (1%) and children with chronic conditions (2%). The adult population's satisfaction with their personal doctor declined (-1%) over the same period.

When analyzing the baseline to DY2 performance trends, the percentage of adults satisfied with their personal doctor increased (1%) as did the percentage of children with chronic conditions (1%). The satisfaction of the child general population declined 1% from the baseline to DY2.

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

For a national average Deloitte used the SPH Analytics benchmark percentage for the adult and child general populations. For the children with chronic conditions population, Deloitte used the QC All Plans benchmark percentage as the SPH Analytics benchmark percentage was not available.

Exhibit 95 –Percentage of Participants Satisfied with Personal Doctor[128]



	Adult	Children with chronic conditions	Child general population
2013 Baseline	80%	87%	89%
DY1 Centennial Care	82%	86%	87%
DY2 Centennial Care	81%	88%	88%
2015 National Avg	80%	87%	88%

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

Measure 96 – Rating of health care.

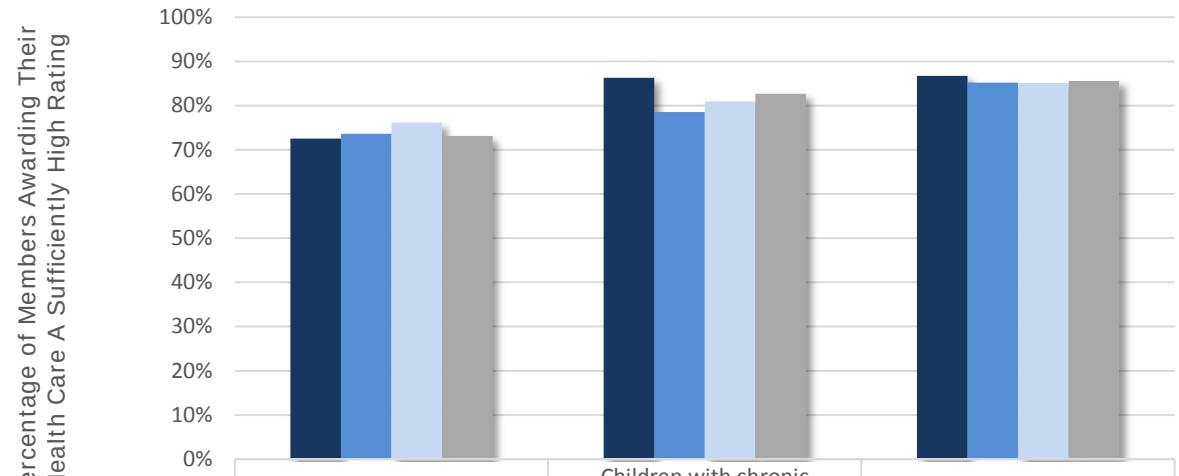
Exhibit 96 presents percentage for the 2013 baseline, DY1, DY2, and an appropriate national average for the percentage of members satisfied with their health care. As illustrated, the satisfaction percentage increased for two of three subcomponents between DY1 and DY2, namely the children with chronic conditions population (3%) and the adult population (3%). The child general population's high percentage of satisfaction with their personal doctor remained stable over the same period.

When analyzing the baseline to DY2 performance trends, the percentage of children with chronic condition satisfied with their health care declined (-6%) as did the percentage of the child general population (-2%). The satisfaction of the adult population increased by 5% from the baseline to DY2.

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

For a national average Deloitte used the SPH Analytics benchmark percentage for the adult and child general populations. For the children with chronic conditions population, Deloitte used the QC All Plans benchmark percentage as the SPH Analytics benchmark percentage was not available.

Exhibit 96 – Percentage of Participants Satisfied with Health Care[129]



	Adult	Children with chronic conditions	Child general population
2013 Baseline	73%	86%	87%
DY1 Centennial Care	74%	79%	85%
DY2 Centennial Care	76%	81%	85%
2015 National Avg	73%	83%	86%

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

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

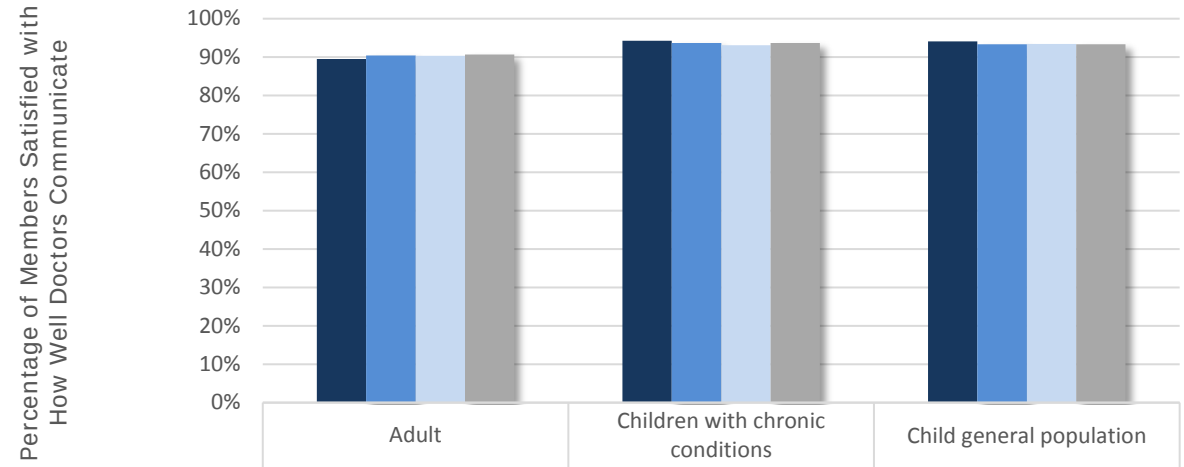
Exhibit 97 presents percentages for the 2013 baseline, DY1, DY2, and an appropriate national average for the percentage of participants satisfied with how well their doctors communicate. As illustrated, the satisfaction percentage remained level for the child general population and the adult population from DY1 and DY2. There was a slight decline for the children with chronic conditions population (-1%) over this period.

When analyzing the baseline to DY2 performance trends, the percentage of adults satisfied with how well their doctors communicate increased (1%) while the satisfaction for the child general population and the children with chronic condition population both declined (-1%). The satisfaction percentage for DY2 were all within 1% of national averages.

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

For a national average Deloitte used the SPH Analytics benchmark percentage for the adult and child general populations. For the children with chronic conditions population, Deloitte used the QC All Plans benchmark percentage as the SPH Analytics benchmark percentage was not available.

Exhibit 97 – Percentage of Participants Satisfied with How Well Their Doctors Communicate[130]



	Adult	Children with chronic conditions	Child general population
2013 Baseline	90%	94%	94%
DY1 Centennial Care	90%	94%	93%
DY2 Centennial Care	90%	93%	93%
2015 National Average	91%	94%	93%

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

Measure 98 – Customer service satisfaction.

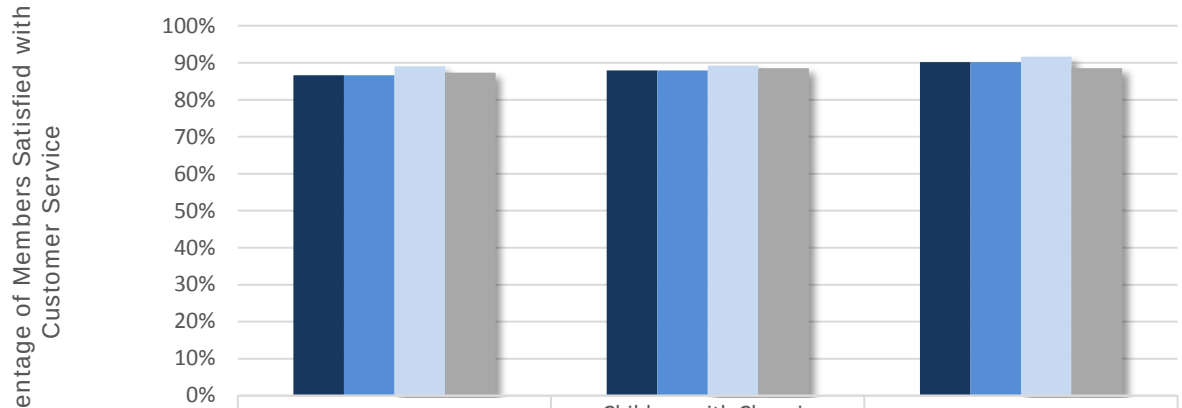
Exhibit 98 presents percentages for the 2013 baseline, DY1, DY2, and an appropriate national average for the percentage of members who were satisfied with customer service. As illustrated, customer service satisfaction percentages increased across all three populations: adult satisfaction increased by 3%, satisfaction for children with chronic conditions increased by 1%, and the child general population satisfaction increased by 2% between DY1 and DY2.

When comparing the baseline to DY2 performance trends, all three populations experienced increases in the satisfaction rates by the same percentages as the DY1 to DY2 increases.

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

For a national average Deloitte used the SPH Analytics benchmark rate for the adult and general child populations. For the children with chronic conditions population, Deloitte used the QC All Plans benchmark rate as the SPH Analytics benchmark was not available.

Exhibit 98 – Customer Service Satisfaction[131]



	Adult	Children with Chronic Conditions	Child general population
2013 Baseline	87%	88%	90%
DY1 Centennial Care	87%	88%	90%
DY2 Centennial Care	89%	89%	92%
2015 National Avg	87%	89%	89%

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

Measure 99 – Rating of specialist seen most often.

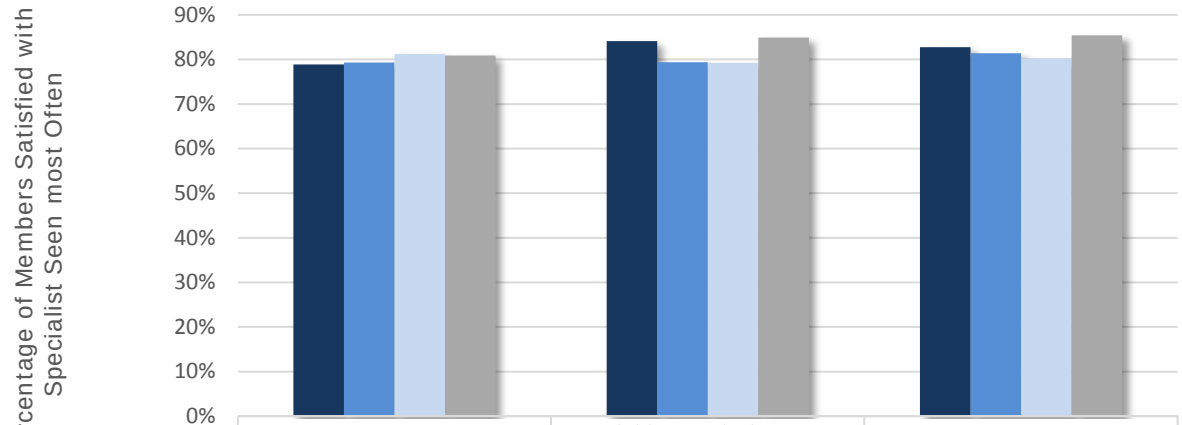
Exhibit 99 presents percentages for the 2013 baseline, DY1, DY2, and an appropriate national average for the percentage of members who were satisfied with the specialist seen most often. As illustrated, satisfaction increased among the adult population (2%) and decreased among the child general population (-1%) from DY1 to DY2. The percentage for the children with chronic conditions population did not change over this period.

When comparing the baseline to DY2 performance trends, the adult satisfaction with specialists increased (3%) while satisfaction declined for both children with chronic conditions (-6%) and child general population (-3%).

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

For a national average Deloitte used the SPH Analytics benchmark percentage for the adult and child general populations. For the children with chronic conditions population, Deloitte used the QC All Plans benchmark percentage as the SPH Analytics benchmark percentage was not available.

Exhibit 99 – Rating of Specialist Seen Most Often[132]



	Adult	Children with chronic conditions	Child general population
2013 Baseline	79%	84%	83%
DY1 Centennial Care	79%	79%	81%
DY2 Centennial Care	81%	79%	80%
2015 National Avg	81%	85%	85%

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

Research Question 4.B

Are provider claims paid accurately and on time?

The Centennial Care program requires contracted MCOs to adjudicate and pay claims accurately and in accordance with prescribed timeliness standards. The program also includes a provider grievance and appeals process with uniform resolution timeliness standards. Centennial Care's streamlined processes are intended to improve the provider experience and increase provider satisfaction with the program. This, in turn, should encourage provider participation and facilitate member access to care.

The Evaluation is reviewing Centennial Care's impact on these processes through the analysis of five measures that address components of claim adjudication, processing, and payment from the health pan to the providers. For each measure, performance is tracked over time against a baseline value and on an annual basis.

Overall through DY2 of the Centennial Care program, the MCOs continue to demonstrate high compliance rates across the measures. There was a favorable decrease in the percentage of claims denied, and the percentage of provider grievances and provider appeals both remained relatively consistent with rates over 99% for both.

Results were mixed across subcomponents for the percentage of clean claims adjudicated; the 30 and 90 day adjudication rates declined slightly, though the 30 day rate was greater than HSD standards of 90%; for claims subject to the 15/30 day standard, the 15-day subcomponent increased slightly while the 30 day component decreased slightly. For each of the four subcomponents, the adjudication rates exceeded 96% in DY2.

The dollar accuracy rate also showed mixed results, as 5 of 10 subcomponents experienced slight decreases in accuracy rates while the others showed slight increases. The crossover claim type subcomponent demonstrated the greatest increase since program inception and is worth noting, as crossover claims are often complex to adjudicate due to the presence of Medicare as an additional payer. All accuracy rate subcomponents exceeded 93% in DY2.

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

Measure 100 – Percentage of clean claims adjudicated within 30/90 days.

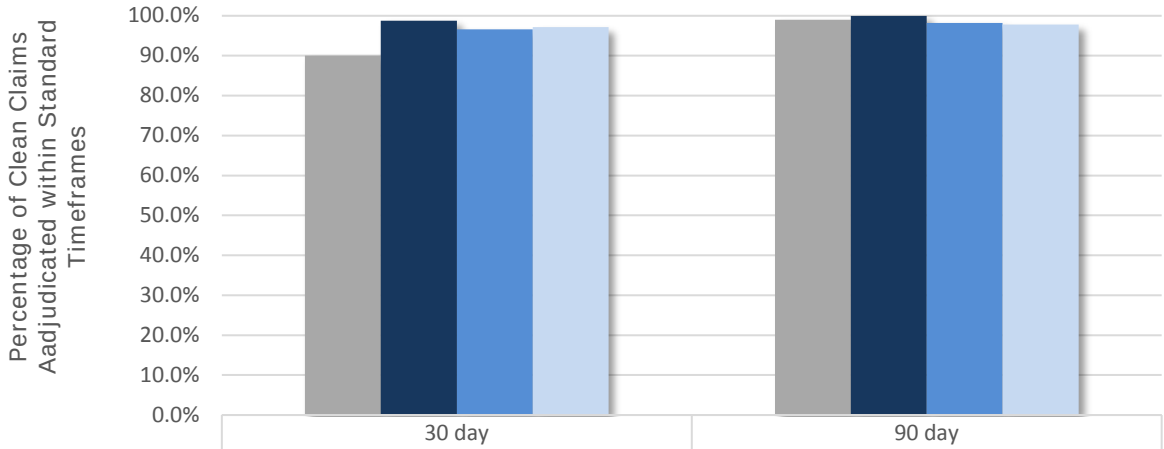
Exhibit 100.a presents the results for SFY 2013, DY1, and DY2 of the rate at which claims with a 30/90 day adjudication standard were resolved within 30 days. As illustrated, the rate increased from DY1 to DY2 by 0.6%. The rate at which these same claims were resolved within the 90 day interval declined slightly by 0.4%.

The rate at which claims with a 30/90 day adjudication standard were resolved within 30 days fell by 1.6% from SFY 2013 to DY2. The rate at which these same claims were resolved within the 90 day standard fell by 2.1% over the same period.

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

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

Exhibit 100.a – Clean Claims Adjudicated within 30/90 Day Standard[133]



	30 day	90 day
HSD Standard	90.0%	99.0%
SFY 2013	98.8%	99.9%
DY1 Centennial Care	96.6%	98.2%
DY2 Centennial Care	97.2%	97.8%

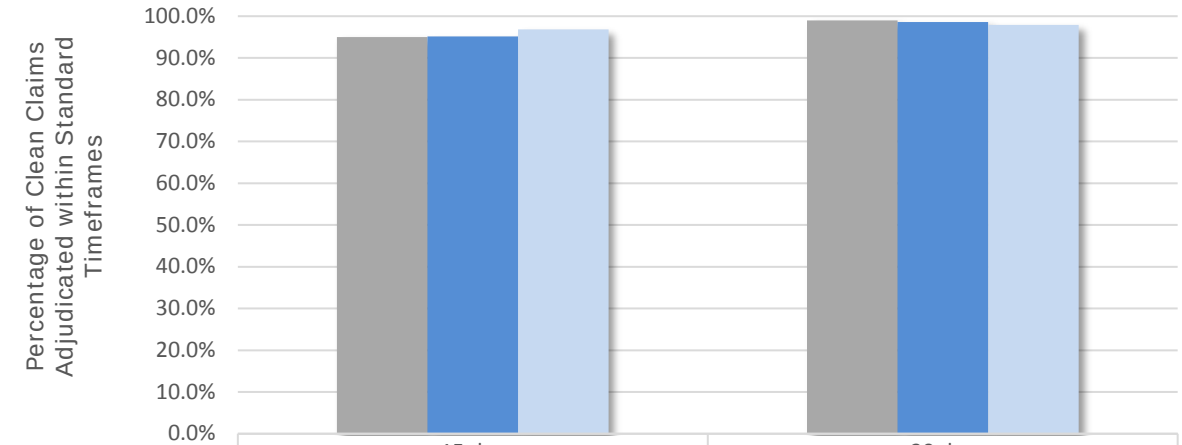
[133] Source: Provider Payment Timeliness Report for SFY 2013; MCO reports for 2014 (HSD 47); ad hoc claims payment and activity reports for 2015.

Exhibit 100.b presents the results for DY1 and DY2 of the rate at which claims with a 15/30 day adjudication standard were adjudicated within 15 days. As illustrated, the rate increased by 1.7% from DY1 to DY2. The rate at which these same claims were adjudicated within the 30 day standard during this same interval declined by 0.7%.

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

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

Exhibit 100.b – Clean Claims Adjudicated within 15/30 Day Standard[134]



	15 day	30 day
HSD Standard	95.0%	99.0%
DY1 Centennial Care	95.2%	98.6%
DY2 Centennial Care	96.8%	97.9%

[134] Source: MCO reports for 2014 (HSD 47); ad hoc claims payment and activity reports for 2015.

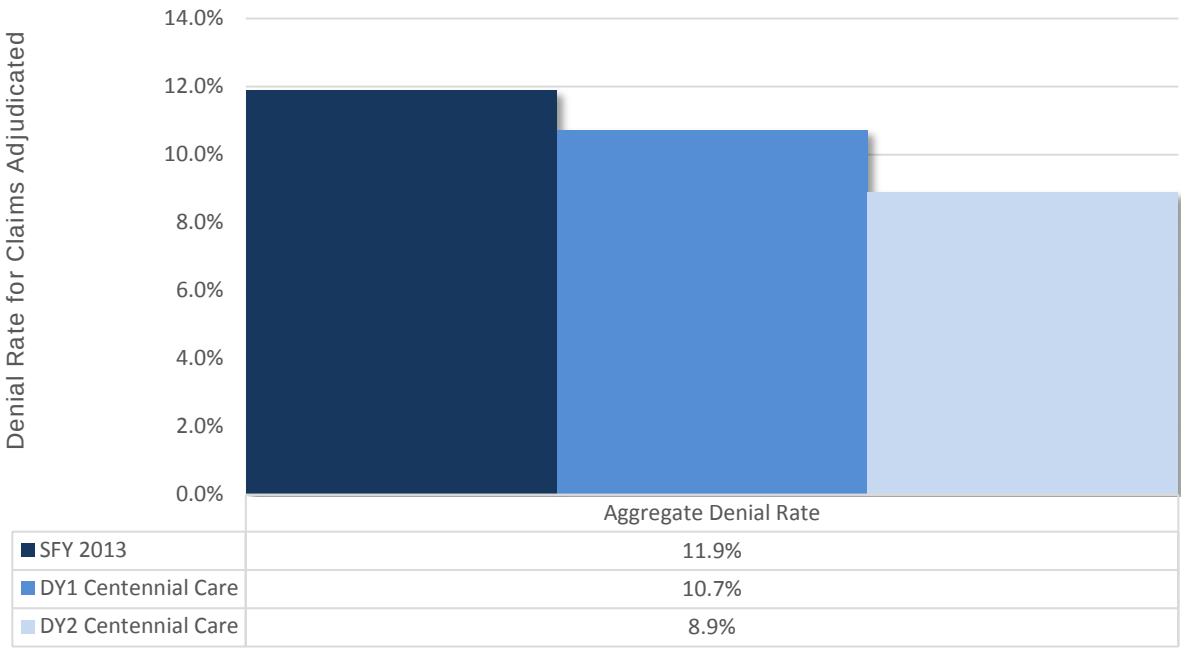
Measure 101 – Percentage of claims denied.

Exhibit 101 presents the results for SFY 2013, DY1, and DY2 of the rate at which claims were denied. As illustrated, the percentage decreased 17.0% from DY1 to DY2. From SFY 2013 to DY2, the rate at which claims were denied fell by 25.2%.

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

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

Exhibit 101 – Percent of Claims Denied[135]



	Aggregate Denial Rate
SFY 2013	11.9%
DY1 Centennial Care	10.7%
DY2 Centennial Care	8.9%

[135] Source: Provider Payment Timeliness Report for SFY 2013; MCO reports for 2014 (HSD 47); ad hoc claims payment and activity reports for 2015.

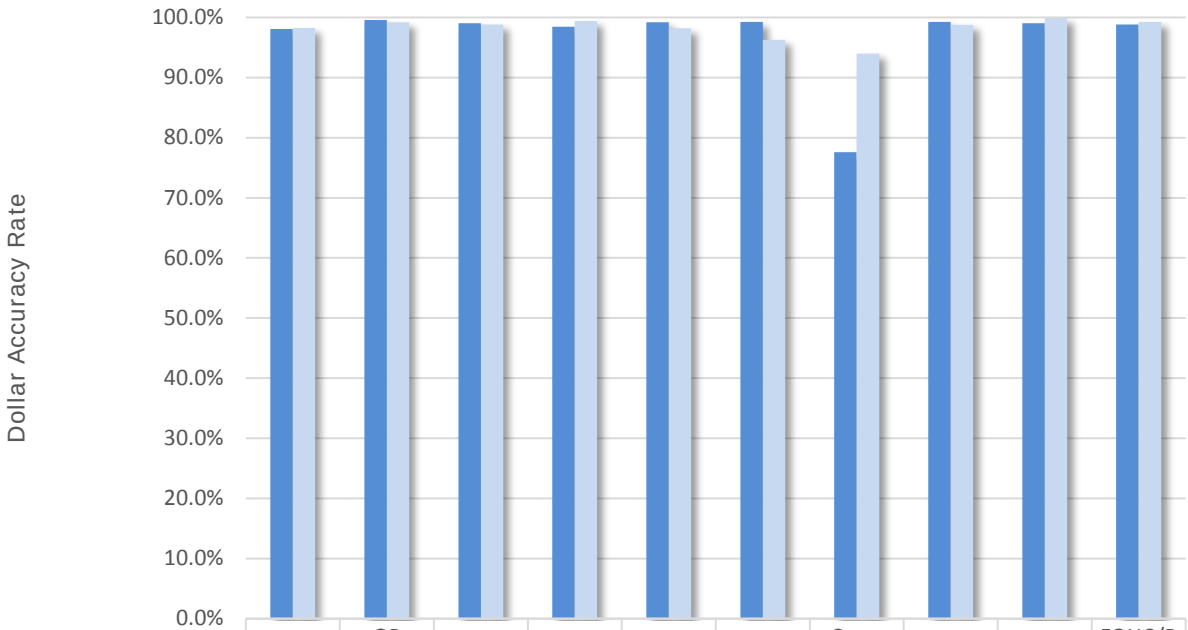
Measure 102 – Dollar accuracy rate.

Exhibit 102 presents results for dollar accuracy rates in DY1 and DY2. For the 10 types of claims reported, 5 showed increases in accuracy rates from DY1 to DY2, a positive development. The claim types that showed increases were inpatient hospital (0.1%), BH (1.0%), cross over (21.1%), dental (0.9%), and FQHC/RHC (0.5%). The claim types that experienced declines in dollar accuracy rates were outpatient hospital (-0.4%), professional (-0.2%), NF (-1.0%), I/T/U (-3.0%), and HCBS (-0.5%) type claims. These changes, whether increases or decreases, were relatively minor as accuracy rates remained high overall.

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

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

Exhibit 102 – Dollar Accuracy Rate[136]



	IP Hosp	OP Hosp	Prof	BH	NF	I/T/U	Cross over	HCBS	Dental	FQHC/RHC
DY1 Centennial Care	98.1%	99.6%	99.1%	98.5%	99.2%	99.3%	77.6%	99.3%	99.0%	98.8%
DY2 Centennial Care	98.2%	99.2%	98.8%	99.4%	98.2%	96.3%	94.0%	98.8%	99.9%	99.2%

[136] Source: MCO reports for 2014 (HSD 46); ad hoc claims payment and activity reports for 2015. For DY2, Deloitte was unable to calculate an aggregate dollar accuracy rate due to data limitations; a dollar accuracy rate for each individual claim type was provided instead.

Measure 103 – Percent of grievances resolved on time.

Exhibit 103 presents rates for DY1 and DY2 of the percentage of provider grievances resolved on time. As illustrated, the rates for timely resolution remained high and were stable from DY1 to DY2, with a 0.0% change.

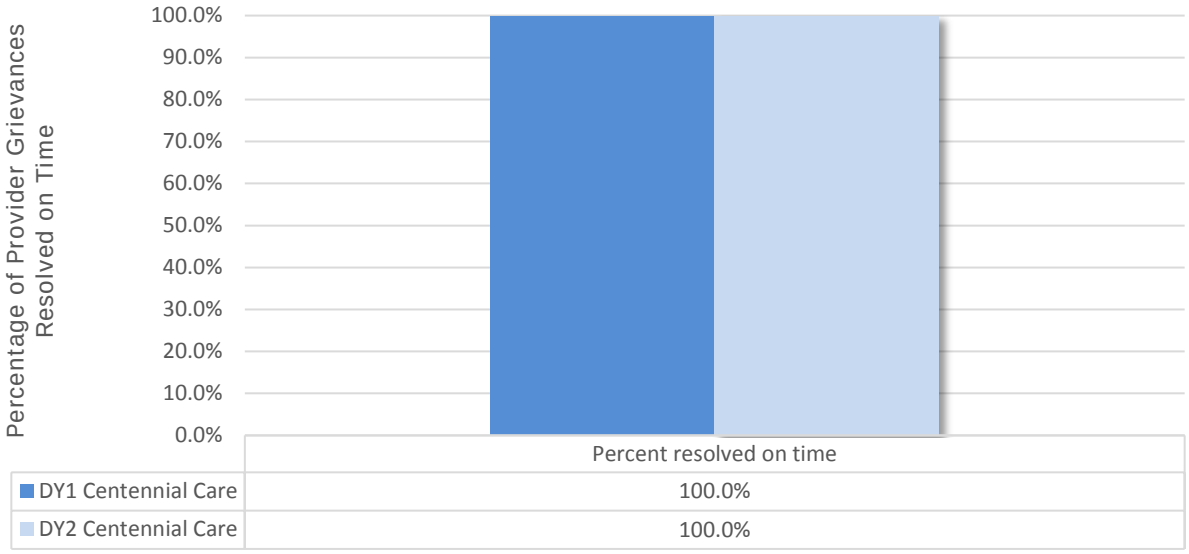
Individual MCO results were consistent with the calculated aggregate, where each MCO experienced 100% timely resolution in DY1 and DY2 with the exception of UHC, who did not produce data for this measure in DY1.

Provisional data is available through November of DY3, which suggests that DY3 rates will likely remain stable from DY2 at 100% timely resolution.

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

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

Exhibit 103 – Percent of Provider Grievances Resolved on Time[137]



[137] Source: MCO reports for 2014 – 2015 (HSD 37).

Measure 104 – Percentage of provider appeals resolved on time.

Exhibit 104 presents rates for DY1 and DY2 of the percentage of provider appeals resolved on time. As illustrated, the rate for timely resolution experienced a marginal increase from DY1 to DY2 by 0.2%.

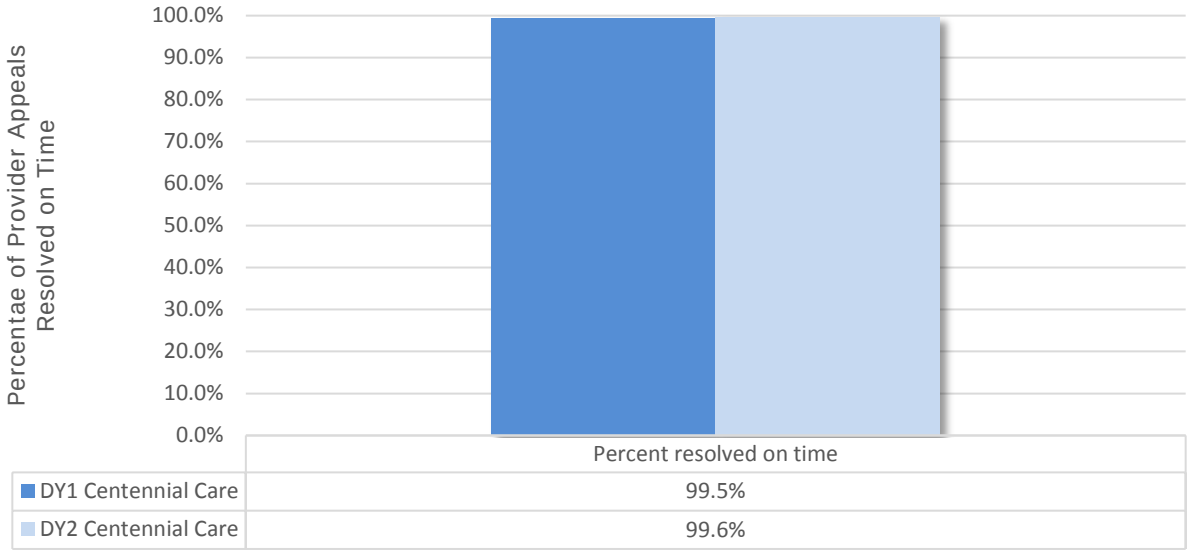
From DY1 to DY2, individual MCO results were also stable, with no MCO experiencing a change of more than 1.0%.

Provisional data is available through November of DY3, which suggests that DY3 rates will likely remain stable from DY2, with timely resolution rates at or above 99.0%.

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

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

Exhibit 104 – Percent of Provider Appeals Resolved on Time[138]



[138] Source: MCO reports for 2014 – 2015 (HSD 37).

Research Question 4.C

Has the state successfully implemented new processes and technologies for program management, reporting, and delivery system reform?

The Centennial Care waiver seeks to improve the efficiency and effectiveness of health care delivery through adoption of new processes and technology.

The Evaluation assesses the impact of program consolidation and adoption of new processes and technologies through analysis of three measures that address use of electronic tools for patient management, implementation of care delivery and payment reforms, claims payment accuracy and program reporting activities. One of these measures evaluates payments made for providers who demonstrate "meaningful use" of electronic health record (EHR) technology, which involves meeting a set of standards and specifications defined by CMS for how the technology is used to improve healthcare. For each measure performance is tracked over time against a baseline value and on an annual basis.

Overall through DY2 of the Centennial Care program, progress continues to be made across all three measures. The number of eligible providers receiving EHR incentive payments has remained steady for hospitals and initial payments continue to increase slightly for professionals. Follow-up payments have declined in recent years however it must be noted that both hospitals and professionals are limited to a specific number of payments within the program, so the decreasing follow-up payments may reflect "aging out" of the incentive program.

In addition, the percentage of claims paid accurately increased across all ten claim-type subcomponents, and PCMH member attribution and hospital/ER utilization (use and outcomes of payment reforms) has shown increases in members attributed to a PCMH and favorable decreases in hospital readmissions, however there were unfavorable increases in ER visits.

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

Measure 106 – Number of eligible providers receiving Electronic Health Record (EHR) incentive payments.

Exhibit 106.a presents rates for 2011 through 2016 of the number of hospitals that received EHR payments.

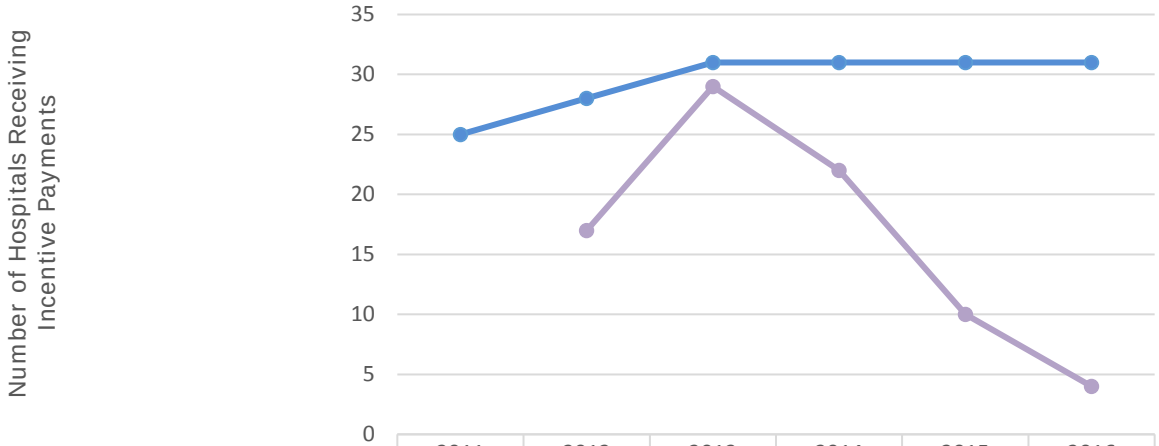
The number of initial hospital payments did not increase from 2015 to 2016. These payments are only available to new participants in their first year of the program and may not be received more than once. This year-to-year stability in the cumulative payments suggests that all hospitals interested in participating in the EHR incentive program and receiving payments have already been engaged. The majority of these hospitals (80.6%) were engaged in 2011 alone.

The number of meaningful use payments showed a 60.0% decrease from 2015 to 2016. This is not necessarily a negative development, as hospitals may only receive EHR payments for three years before they are no longer eligible. Over 88% of the meaningful use payments that could possibly be made, based on the number of providers in the program, have already been made.

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

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

Exhibit 106.a – Number of Hospitals Receiving EHR Incentive Payments[139]



	2011	2012	2013	2014	2015	2016
Initial Payment (cumulative)	25	28	31	31	31	31
Meaningful Use Payment (per year)		17	29	22	10	4

Exhibit 106.b presents the number of professional providers that received incentive payments from 2011 to 2016.

The incremental increase in the number of initial payments made to eligible professionals decreased by 47.1% from 2015 to 2016, but this decline is not necessarily negative. Similar to the hospital payments, there are limitations on the EHR payments. Each provider may receive an initial payment once, so a decrease in the number of providers receiving those payments may be reflective of the relatively smaller number of professional providers yet to be involved in the program. In addition, the University of New Mexico Medical Group came back into the EHR program in 2015, with associated eligible professionals receiving initial payments and meaningful use payments. This event greatly

[139] Source: HSD ad hoc reports for 2014 – 2016.

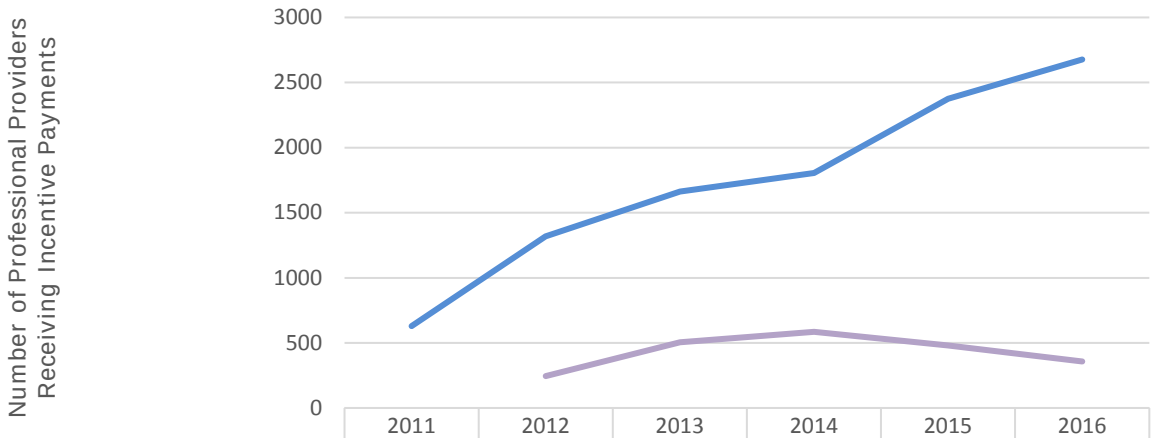
increased the number of initial EHR payments in 2015, and therefore a subsequent drop in the number of initial payments in 2016 was to be expected.

The number of meaningful use payments dropped from 2015 to 2016 by 25.6%. As with the hospital meaningful use payments, there is a six-payment limit for any one eligible professional, so a decline may be reflective of a smaller number of professionals still eligible and an overall effective program. In addition, the 2016 meaningful use count is affected by a problem encountered by the University of New Mexico Medical Group, a source of many of the eligible providers within the state. Providers of this group were unable to successfully attest and this likely affected the 2016 payment count.

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

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

Exhibit 106.b – Number of Eligible Professionals Receiving EHR Incentive Payments[140]



	2011	2012	2013	2014	2015	2016
Initial Payment (cumulative)	629	1319	1662	1804	2375	2677
Meaningful Use Payment (per year)		245	504	585	480	357

[140] Source: HSD ad hoc reports for 2014 – 2016.

Measure 108 – Percentage of claims paid accurately.

Exhibit 108 presents results for DY1 and DY2 of the percentage of claims paid accurately. For each of the ten types of claims reported, accuracy rates increased from DY1 to DY2.

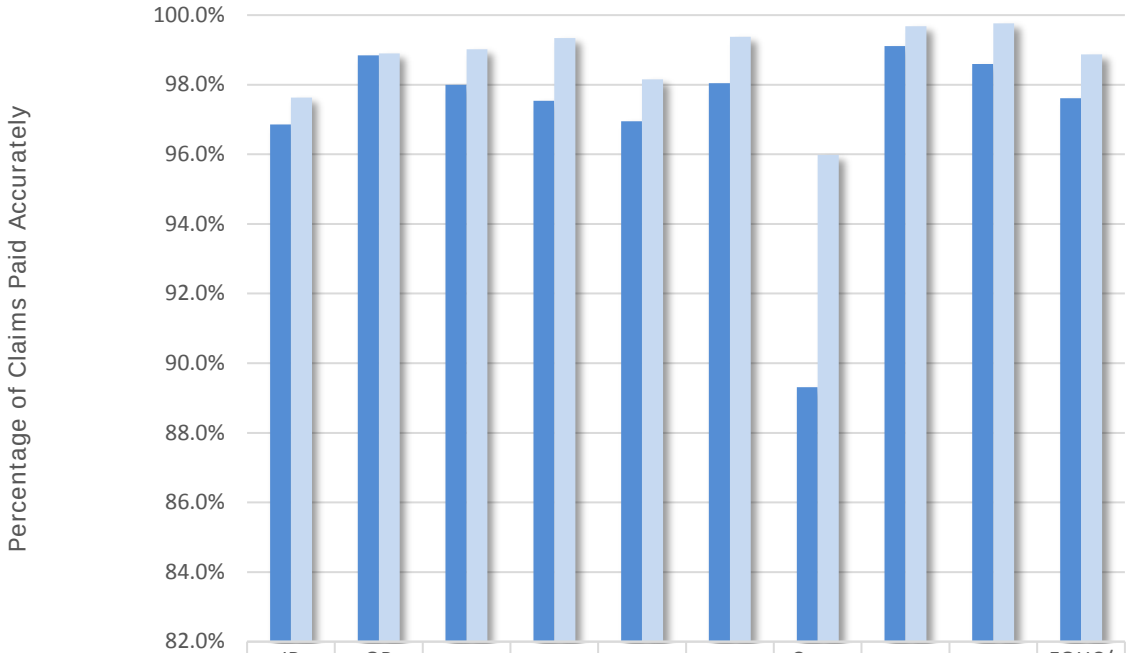
The increases were 0.8% for inpatient hospital, 0.1% for outpatient hospital, 1.0% for professional, 1.9% for BH, 1.2% for NF, 1.4% for I/T/U, 7.5% for cross over, 0.6% for HCBS, 1.2% for dental, and 1.3% for FQHC/RHC.

DY3 results were developing as this narrative was being drafted, but not in sufficient detail to merit being provisionally included in this analysis.

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

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

Exhibit 108 – Percentage of Claims Paid Accurately[141]



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

[141] Source: MCO reports for 2014 (HSD 46); ad hoc claims payment and activity reports for 2015. For DY2, Deloitte was unable to calculate an aggregate payment accuracy rate due to data limitations; a payment accuracy rate for each individual claim type was provided instead.

Measure 109 –PCMH member attribution and hospital/ER utilization (use and outcomes of payment reforms).

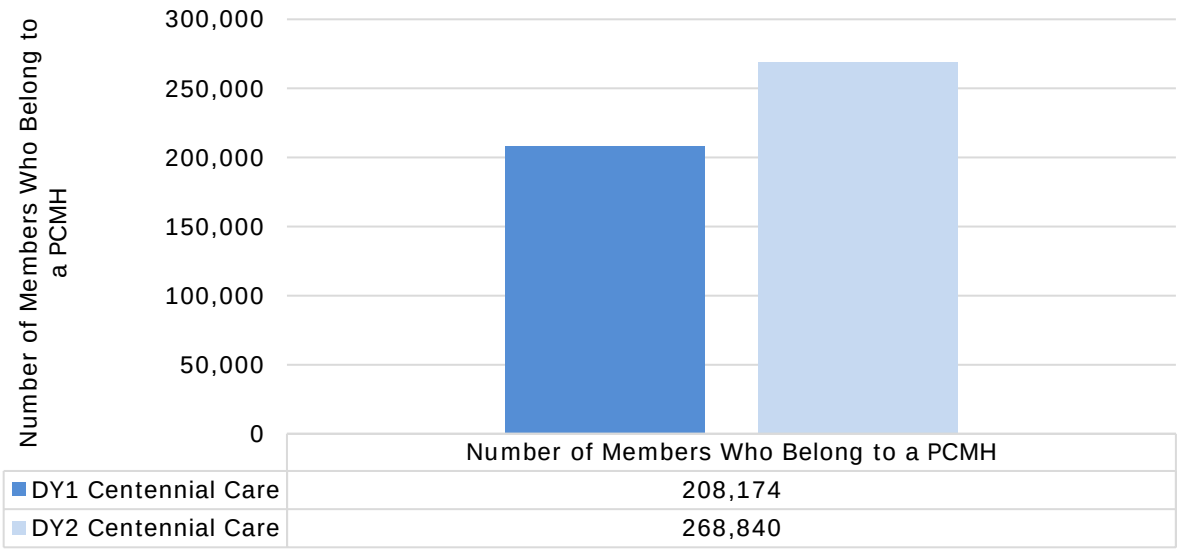
Exhibits 109.a and 109.b presents results for DY1 and DY2 for PCMH membership attribution and the Hospital/ER Utilization impact for members attributed to a PCMH. This definition is being used as an alternative for "use and outcomes of payment reforms" since the data source for this measure focuses on PCMHs and impact on member readmissions as opposed to all payment reform projects (ACOs, gainsharing, etc.).

As illustrated, the number of members who belong to PCMH increased by 29.1% from DY1 to DY2. There were declines in the percentage of PCMH members with a hospital readmission within 30 days of a pervious hospital admission (-34.5%) and in the percentage of PCMH members with one ED visit during the year (-6.3%). There were also increases in the percentage of members with a PCMH visit seven days after an ED visit (2.9%), the percentage of members with two or three ED visits (48.3%), and the percentage of members with four or more ED visits (130.9%), though the percentage with four or more visits was below 3.0%.

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

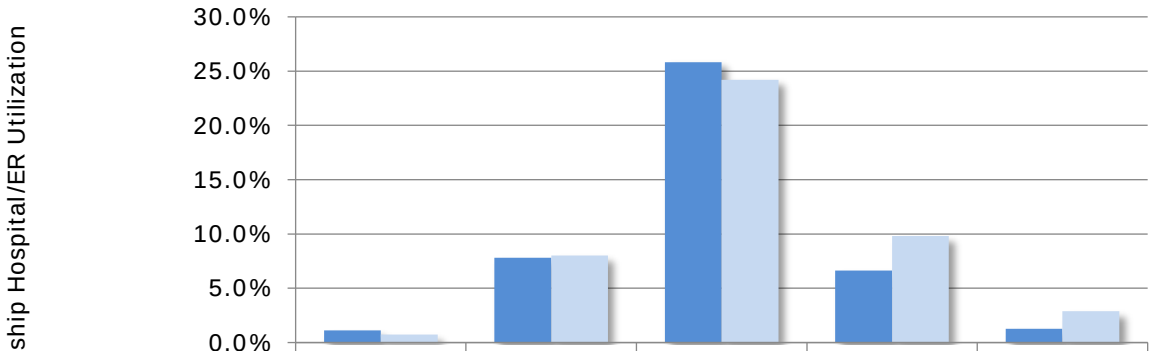
No national benchmark rate could be identified for this measure.

Exhibit 109.a – Number of Members who Belong to a PCMH[142]



[142] Source: MCO reports for 2014 – 2015 (HSD 48).

Exhibit 109.b – PCMH Membership Hospital/ER Utilization[143]



	Percent PCMH members readmitted to a hospital within 30 days of a previous hospital admission	Percent PCMH members seen at the PCMH site within 7 days following a hospital admission or emergency departme…	Percent PCMH members who visited the emergency departmen t 1 time during the reporting period	Percent PCMH members who visited the emergency departmen t 2-3 times during the reporting period	Percent PCMH members who visited the emergency departmen t 4 or more times during the reporting period
DY1 Centennial Care	1.1%	7.8%	25.8%	6.6%	1.3%
DY2 Centennial Care	0.7%	8.0%	24.2%	9.8%	2.9%

[143] Source: MCO reports for 2014 – 2015 (HSD 48).

Conclusion

The Centennial Care 1115 Waiver program is largely progressing on the major designated goals to date. One significant change to the program was that total Centennial Care member months increased by about 1,306,000, or 17.8%, from DY1 to DY3. The vast majority of this increase was driven by the Medicaid expansion group, which grew by 63.3%.

Major Centennial Care program goals include commitments to improving care access, enhancing care coordination and integration, improving the quality of care, reducing the growth trend in program expenditures, increasing member engagement and satisfaction, and implementing new processes and technologies:

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

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

- **Improving Care Coordination** – The Evaluation generally noted improvements in care coordination activities. Improvements were observed in the percentage of members the MCOs were able to engage, the percentage of members for whom HRAs were completed, and the percentage of Level 2 and level 3 members who received telephonic and in-person outreach.

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

- **Improving Care Integration** – The Evaluation noted mixed progress in care integration activities. Improvements were noted in the increased percentage of members who had a BH service and also received outpatient ambulatory visits and a favorable decline in the ER visit rates among members with BH needs. Rates also increased for members with LTSS who accessed BH services, and members who accessed a BH service who also accessed HCBS.

  Conversely, performance declined for ER visit rates for LTSS members, diabetes screening for members with schizophrenia or bipolar disorder, diabetes monitoring for members with diabetes and schizophrenia, and the percentage of members accessing both BH services and PCP Visits.

- **Improving Quality of Care –** The Evaluation found continued improvements in quality of care as noted in the findings for the assigned performance measures. There were

improvements in the EPSDT screening ratios; increases in monitoring rates of BMI for adults, children and adolescents; and increases in asthma medication management. Hospital admission rates also decreased across nearly all ACS measures. Finally, there was a decline in the percentage of ER visits that were potentially avoidable and fall risk intervention.

Conversely, performance declined for asthma medication ratios, smoking and tobacco use cessation, annual patient monitoring for persistent medications, and inpatient admissions to psychiatric hospitals and RTCs.

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

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

  The Evaluation also found negative changes in utilization for certain measures. There was a decline in performance from the baseline to DY3 for diagnostic imaging costs, hospital costs, and ED utilization, all of which experienced unfavorable increases.

- **Increased Member Engagement** – There was a significant increase in the number of members becoming enrolled in the Centennial Rewards program and performing various wellness-related activities designed to earn rewards under the program; at the end of DY1, approximately 47,000, or 7.1% of eligible members, were registered for the program. At the end of DY2, approximately 156,000, or 20.2% of eligible members were registered for the program. There are over 40 activities members can perform to earn rewards from adhering to monthly prescriptions to getting an annual dental visit. In all 40 categories, the percentage of members earning rewards (i.e. performing a health/wellness activity) increased through DY2.

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

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

- **Implementing New Processes and Technologies** – The three measures for which there are sufficient data showed mixed results through DY2. There were improvements in the percentage of claims paid accurately increased across all claim types and the number of members attributed to a PCMH under a payment reform program. Conversely, incentive payments for EHR use either increased, decreased, or experienced little change depending on the type of provider and type of payment made.

In conclusion, the Centennial Care waiver demonstration has yielded many promising results and progress made aligning with the four hypotheses set forth in the Evaluation Design Plan. Certain areas were identified for improvement in future years, and while many aspects of the program are demonstrating positive results, the Evaluation would expect continued progress as the program matures, and as HSD continues to work with the MCOs to continue to enhance the program.

Appendix

A. Measure Definition and Evaluation Methodology

Measure	Measure Name	Definition	Evaluation Methodology	
1	Access to preventive/ambulatory services among Centennial Care members in aggregate and within subgroups	"Access to Preventive/Ambulatory Health Services" is a Healthcare Effectiveness Data and Information Set (HEDIS) measure that reports the percentage of adults ages 20 and older who had an ambulatory or preventive care visit during the measurement year. It provides important information about the accessibility of primary/preventive services for adult Centennial Care enrollees. To be counted under this measure, members must have been enrolled on the last day of the measurement year and must not have had more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a one-month gap in coverage.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
2	Mental health services utilization	"Mental Health Utilization" is a HEDIS measure that reports the number and percentage of enrolled members receiving any mental health service during the measurement year with mental health as the principal diagnosis based on the HEDIS mental health diagnosis value set. It provides important information about the availability of mental health services to Centennial Care enrollees.	DY1 to DY2	The MCOs under the Salud and CoLTS programs did not report on this measure in 2013. Therefore, CY 2014 Centennial Care data will be utilized as the baseline. HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for

Measure	Measure Name	Definition	Evaluation Methodology	
		The measure applies to members of all ages. The service types counted in the measure include: • Inpatient care at either a hospital or a treatment facility (including residential care and rehabilitation facilities) with mental health as the principal diagnosis • Intensive outpatient and partial hospitalization encounters in conjunction with a principal mental health diagnosis, whether treated by a physician or non-physician • Outpatient and ED encounters in conjunction with a principal mental health diagnosis, whether treated by a physician or non-physician.		comparison purposes only; it is not an audited HEDIS rate.
3	Number of telemedicine providers and telemedicine utilization	"Number of Telemedicine Providers and Telemedicine Utilization" is a measure that reports the number of units of service rendered via telemedicine during the measurement year. As a rural state, New Mexico has the potential to improve access to care through greater use of technology such as telemedicine/telehealth. In Amendment Number 3 to the Centennial Care Agreement, HSD defined the following Telehealth Delivery Service Improvement Target: *"A minimum of a fifteen percent (15%) increase in telehealth "office" visits with specialists, including behavioral health providers, for members in rural and*	Baseline	For the 2013 baseline rate, HSD furnished Deloitte with telemedicine visit data obtained through ad hoc reports filed by the four Centennial Care MCOs. The MCOs followed a consistent methodology in terms of services included and excluded from the data. For example, services in urban areas and services associated with Project ECHO were not counted as telemedicine visits. However, behavioral health services in 2013 were provided by a separate behavioral health organization and one of the four MCOs reported that it did not include BHO telemedicine activity for its members in its 2013 data. Therefore, 2013 behavioral health visit count provided appears to understate total activity for the year.

Measure	Measure Name	Definition	Evaluation Methodology	
		frontier areas. At least five percent (5%) of the increase must be visits with behavioral health providers." Each of the Centennial Care Managed Care Organizations (MCOs) has undertaken steps to increase the use of telemedicine around the state. For example, one MCO recently launched an initiative to provide urgent behavioral health care through its telehealth platform. Another has begun providing tele-dermatology consultations to primary care physicians and tele-pulmonology services for clinically fragile members in rural and frontier areas. The measure examines the number of telemedicine professional services (visits) occurring each year in rural/frontier New Mexico, with behavioral and physical health visits separately reported.		For the DY1 and DY2 counts, HSD again furnished telemedicine visit data obtained through ad hoc reports filed by the four Centennial Care MCOs.
4 and 5	Number and percentage of people meeting nursing facility level of care who are in a nursing facility/receive home-and community-based services	Centennial Care members who meet financial and clinical eligibility criteria for nursing facility level of care may receive long term care services either in a nursing facility or in their home or another community setting. Members have the right to receive long term care in a community-based setting when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into	Baseline to DY3	For both NF and HCBS rates for all years, Deloitte was provided with rates by HSD with no additional data regarding numerators, denominators, or overall counts. The data is driven by membership in INF and community benefit cohorts (consisting of ADB, ANW, SDB, and SNW) and the analysis of encounter data was performed by Mercer.

Measure	Measure Name	Definition	Evaluation Methodology	
		account the resources available to the public entity and the needs of others who are receiving services from the entity. Although nursing facilities remain an essential care setting, HCBS settings are often preferred by members and are, on average, less costly than nursing facilities. One of the objectives of Centennial Care is to gradually "re-balance" where members are served, from institutional to HCBS settings. This combined measure identifies the portion of the population at the nursing facility level of care that resides in a nursing facility and the portion residing at home or in the community and receiving HCBS. (Measures 1.4.A and 5 have been combined to avoid redundancy.)		
6	Number and percentage of people with annual dental visit	"Annual Dental Visit" is a HEDIS measure defined as the percentage of members 2–21 years of age who had at least one dental visit during the measurement year. It provides important information about the accessibility of dental services for younger Centennial Care members. To be counted under this measure, members must fall into the range of 2–21 years of age on December 31 of the measurement year and must have had no more than one gap in coverage of up to 45 days.	Baseline to DY2	For the Baseline calculation, HSD furnished Deloitte with audited HEDIS data for three of the four plans contracted under the Salud! program and one of the two plans contracted under the CoLTS program. The total enrollment in 2013 of the four plans provided represented 75% of total combined Salud!/CoLTS membership. HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for

Measure	Measure Name	Definition	Evaluation Methodology	
				comparison purposes only; it is not an audited HEDIS rate. For the national comparison rate, a 2015 National Medicaid HMO rate as reported by the National Committee for Quality Assurance (NCQA) was used. For this rate, neither numerator nor denominator was provided. Instead, individual rates were provided for each age group (2 – 3 years; 4 – 6 years; 7 – 10 years; 11 – 14 years; 15 – 18 years; and 19 – 21 years). Each rate was weighted based on the number of years the rate measured (two, three, four, four, four, and three, respectively) and took the average using the total number of years accounted for in the measurement (twenty). This methodology assumes that the program has approximately an even distribution of members across ages two to twenty-one. If this is not the case, the average rate reported could be either lower or higher.
7	Enrollment in Centennial Care as a percentage of state population	"Enrollment in Centennial Care" is a measure that reports the percentage of New Mexico residents who were enrolled in Centennial Care during the measurement year. New Mexico is one of 31 states and the District of Columbia to expand eligibility for Medicaid under the terms of the Affordable Care Act. Centennial Care's potential for improving the health of New Mexicans is dependent on the state's success in enrolling and recertifying timely persons eligible for the program. To be counted under this measure, members had to be included in enrollment reported by MCOs. State	DY1	HSD furnished Deloitte with statewide analyses developed by Mercer that included member months for the Centennial Care population. This count was divided by 12 to estimate an average annual membership over the calendar year and served as the numerator for this measure in each respective year. For the denominator, Deloitte used publicly available population estimates from the United States Census Bureau. Annual state population estimates are made on July 1 of the measurement year.

Measure	Measure Name	Definition	Evaluation Methodology	
		population estimates are from the U.S. Census Bureau.		
8	Native American members opting-in and opting-out of Centennial Care	Enrollment in managed care is only mandatory for Native Americans who are nursing facility level of care eligible; other Native Americans have the right to opt-out of managed care and to receive care through the fee-for-service system. The opt-out rate is a useful proxy for assessing the managed care program's perceived value among Native Americans who have a choice of systems for their care. Centennial Care plans provide monthly data to HSD on the number and percentage of Native Americans opting-in and out of the program. Note that this measure does not control for changes in size of the Centennial Care-eligible Native American population. Deloitte did not use Q1 2014 data to construct a baseline as it did in some other measures because Native American enrollment may have been significantly different under predecessor programs, a distinction which a baseline constructed from 2014 data would have been unable to capture. Using the count from an individual month (December) was appropriate because this measure reflects a distribution of potential	DY1 to DY3	The MCOs under the Salud and CoLTS programs did not report on this measure in 2013. Therefore, DY1 data will be utilized as the baseline. HSD furnished Deloitte with the monthly reports submitted by the four Centennial Care plans in DY1, DY2, and DY3. Therefore, we used the December reports for each year, which captured the opt-in/opt-out rate at the end of the calendar year. (The rate varied only slightly from month-to-month.) For the opt-in figure, the numerator was the number of Native Americans electing to be a part of the Centennial Care program, while the opt-out number was the number of Native Americans who chose not to be included. The denominator was the sum of the opt-in and opt-out counts across the four plans.

Measure	Measure Name	Definition	Evaluation Methodology	
		members at a point in time. December was the most appropriate month because it is furthest in time from the commencement of services.		
10	Number and percentage of participants with BH conditions who accessed any of the three new BH services (respite, family support, and recovery)	The Centennial Care program expanded behavioral health coverage by adding three services intended to support the program's person-and family-centered care model. The services are respite, family support, and recovery. HSD requires Centennial Care plans to submit encounter data on service activity. The data can be used to profile service utilization, by service type, at the member level.	DY1 to DY3	The MCOs under the Salud and CoLTS programs did not report on this measure in 2013. Therefore, calendar year 2014 Centennial Care data was utilized as the baseline. HSD furnished Deloitte with a count of members who received both BH services and the enumerated specialty services as well as a count of total managed care population in each year. Deloitte calculated resulting percentages by dividing the former by the latter.
11	Number and percentage of unduplicated participants with at least one PCP visit	Regular visits with a PCP is a central feature of delivering coordinated care. PCPs fill many important roles in the care coordination process, including ensuring continuity of care, identifying health problems early, delivering preventive care, and referring members to appropriate specialists. Centennial Care encourages members to visit their PCP at least once annually.	Baseline to DY3	HSD furnished Deloitte with MMIS reports that included a count of the entire managed care population and a count of members that had at least one PCP visit during the measurement year. The visit count was divided by the population count for an overall rate for each year.
12	Number/ratio of participating providers to enrollees	The number of available providers relative to members is an important ratio that provides insight into whether the provider network is growing or shrinking relative to membership. A lower member-to-provider ratio indicates a greater available capacity in	DY1 to DY2	HSD furnished Deloitte with quarterly HSD 3 reports for the four Centennial Care MCOs. Deloitte calculated an average number of providers based on unique provider names/IDs across the MCOs in each quarter (to avoid double-counting providers that operate in multiple MCO networks). The unique quarterly providers were summed and divided by

Measure	Measure Name	Definition	Evaluation Methodology	
		the provider network to provide services.		four to arrive at an average annual number of providers as the denominator. The numerator was member months from the Mercer dashboard data that supports Measure 7, divided by twelve to arrive at the average annual members.
13	Percentage of primary care providers with open panels	The ease with which Centennial Care members are able to access primary care is partly dependent on the percentage of PCPs who have open panels and are able to accept new patients into their practices. If a large percentage of panels are closed, members may find it difficult to locate a PCP near where they live or work, reducing their ease of access to preventive care and increasing the risk that they will go to an emergency room for a non-emergent problem. HSD requires Centennial Care plans to report quarterly on the number of PCPs with open and closed panels.	DY1 to DY2	HSD furnished Deloitte with quarterly HSD 3 reports for the four Centennial Care MCOs. Deloitte calculated an average number of open and closed panels based on quarterly count data. The denominator for the measure was the sum of the open and closed panel counts.
14	Number and percentage of substance use disorder participants with follow-up 7 and 30 days after leaving Residential Treatment Center (RTC)	"Number and Percentage of Substance Use Disorder Participants with follow-up 7 and 30 days after Leaving Residential Treatment Center (RTC)" is a HSD measure that reports the number and percentage of substance use disorder participants with follow-up 7 and 30 days after leaving RTC. These are reported as two separate rates and closely resemble the HEDIS measure that reports "Follow-up after hospitalization of mental illness."	DY1 to DY2	HSD furnished Deloitte with HSD5 reports containing the count of RTC discharges as well as follow-up visits within 7 and 30 days of discharge in each year.

Measure	Measure Name	Definition	Evaluation Methodology	
15	Number and percentage of BH participants with follow-up after hospitalization of mental illness	"Number and Percentage of BH Participants with Follow-up after Hospitalization of Mental Illness" is a HEDIS measure that assesses adults and children six years of age and older who were hospitalized for treatment of selected mental health disorders and had an outpatient visit, an intensive outpatient encounter, or a partial hospitalization with a mental health practitioner. The measure identifies the percentage of members who received follow-up within 7 days of discharge and within 30 days of discharge.	DY1 to DY2	The MCOs under the Salud and CoLTS programs did not report on this measure in 2013. Therefore, CY 2014 Centennial Care data will be utilized as the baseline. HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
16	Childhood immunization status	"Childhood Immunization Status" is a HEDIS measure that reports the percentage of children two years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); two H influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	Baseline	HSD furnished Deloitte with audited HEDIS data for three of the four MCOs (UHC did not report on this measure in 2013). Deloitte combined the three plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the three MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
			DY1 to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
17	Immunizations for adolescents	"Immunizations for Adolescents" is a HEDIS measure that reports the percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate. It provides important information about the timeliness of primary care/preventive services for Centennial Care children.	Baseline	HSD furnished Deloitte with audited HEDIS data for three of the four MCOs (BCBS did not report on this measure in 2013). Deloitte combined the three plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the three MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
			DY1 to DY2	HSD furnished Deloitte with audited HEDIS data for four MCOs. Deloitte only combined the numerator and denominator values of three plans that used the same reporting methodology to calculate an aggregate rate each year. Although to our knowledge the three MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
18	Well-child visits in first 15 months of life	"Well-Child Visits in First 15 Months of Life" is a HEDIS measure that reports the percentage of child members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: • No well-child visits • One well-child visits • Two well-child visits • Three well-child visits • Four well-child visits • Five well-child visits • Six or more well-child visits	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for three MCOs (UHC did not report on this measure) in 2013 and 2014, and four MCOs in 2015. Deloitte compared individual rates (and did not calculate aggregate rates) for the MCOs since two MCOs used a hybrid reporting methodology while two used an administrative reporting methodology in 2015.

Measure	Measure Name	Definition	Evaluation Methodology	
19	Well-child visits in third, fourth, fifth and sixth years of life	"Well-Child Visits in Third, Fourth, Fifth and Sixth Years of Life" is a HEDIS measure that reports the percentage of members 3 – 6 years of age who received one or more well-child visits with a PCP during the measurement year.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for three MCOs (UHC did not report on this measure) in 2013, and four MCOs in 2014 and 2015. Deloitte compared individual rates (and did not calculate aggregate rates) for the MCOs since two MCOs used a hybrid reporting methodology while two used an administrative reporting methodology in 2014 and 2015.
20	Adolescent well care visits	"Adolescent Well Care Visits" is a HEDIS measure that reports the percentage of enrolled members 12 – 21 years of age who had at least one comprehensive well-care visit with a PCP or an Obstetrician/Gynecologist (OB/GYN) practitioner during the measurement year. It provides important information about the timeliness of primary care/preventive services for Centennial Care children.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for four MCOs in each year. Deloitte compared individual rates (and did not calculate aggregate rates) for the MCOs since two MCOs used a hybrid reporting methodology while two used an administrative reporting methodology in 2014 and 2015.

Measure	Measure Name	Definition	Evaluation Methodology	
21	Prenatal and postpartum care	"Prenatal and Postpartum Care" is a HEDIS measure that reports the percentage of enrolled members 12 – 21 years of age who had at least one comprehensive well-care visit with a PCP or an Obstetrician/Gynecologist (OB/GYN) practitioner during the measurement year. It provides important information about the timeliness of primary care/preventive services for Centennial Care children.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
22	Frequency of ongoing Prenatal care	"Frequency of Ongoing Prenatal Care" is a HEDIS measure that reports the percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following number of expected prenatal visits: • <21 percent of expected visits • 21 percent–40 percent of expected visits • 41 percent–60 percent of expected visits • 61 percent–80 percent of expected visits • ≥81 percent of expected visits This measure provides important information about the timeliness of primary care/preventive services for pregnant Centennial Care members.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
23	Breast cancer screening	"Breast Cancer Screening" is a HEDIS measure that reports the percentage of women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years. This measure provides important information about the timeliness of primary care/preventive services for pregnant Centennial Care members.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
24	Cervical cancer screening for women	"Cervical Cancer Screening for Women" is a HEDIS measure that reports the percentage of women 21 to 64 years of age who were screened for cervical cancer using either of the following criteria: • Women age 21 to 64 who had cervical cytology performed every 3 years; or • Women age 30 to 64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years. This measure provides important information about the timeliness of primary care/preventive services for pregnant Centennial Care members.	Baseline to DY1	HSD furnished Deloitte with audited HEDIS data for four MCOs. Deloitte only combined the numerator and denominator values of three plans that used the same reporting methodology to calculate an aggregate rate each year. Although to our knowledge the three MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
			DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
25	Flu vaccinations for adults	"Flu Vaccinations for Adults" is a HEDIS-based measure that assesses the percentage of adults 18–64 years of age who report receiving an influenza vaccination. To be counted under this measure, members must be adults age 18-64 as of December 31 of the measurement year.	Baseline to DY3	HSD furnished Deloitte with MMIS reports containing counts of the total managed care adult population and unique members who had a flu vaccination.
26	Initiation and engagement of alcohol and other drug (AOD) dependence treatment	"Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment" is a HEDIS measure that assesses the percentage of adolescents and adults with a new episode of AOD dependence who received the following care: • Initiation of AOD Treatment: The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment: The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. The measure reports two age stratifications (13–17 years and 18+ years) for both initiation and engagement of AOD treatment, as well as a total rate. It is meant to provide important information about the	DY1 to DY2	No MCO reported on this measure in 2013, and thus 2014 data is used as the baseline. HSD furnished Deloitte with audited HEDIS data for three MCOs (UHC did not report on this measure) in each year. Deloitte combined the three plans' numerator and denominator values to calculate an aggregate rate. Although to our knowledge the three MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		timeliness of substance abuse treatment services for Centennial Care members.		

Measure	Measure Name	Definition	Evaluation Methodology	
27	Geographic Access Measures	"Geographic Access Measures" is a measure developed by HSD as a way to evaluate access to primary care for Centennial Care enrollees across the State of New Mexico. HSD has developed standards for measuring geographic-based access to care which MCOs reported by quarter in quarterly geographic access reports (Report 55): • Urban Counties = 90% of members have access to a PCP within 30 miles • Rural Counties = 90% of members have access to a PCP within 45 miles • Frontier Counties = 90% of members have access to a PCP within 60 miles	DY1 to DY2	HSD furnished Deloitte with HSD 55 quarterly reports containing member counts, percentage of members with access to PCPs, and PCP counts by county type. Deloitte combined quarterly counts of total members, members with access to PCPs, and PCP counts across MCOs to produce aggregate annual results of percentage of members with access to PCPs and member to PCP ratios by county type.

Measure	Measure Name	Definition	Evaluation Methodology	
28	Number and percentage of participants with health risk assessments (HRA) completed within contract timeframes	"Number and Percentage of Members with HRAs Completed within Contract Timeframes" is a measure developed by HSD as a way to evaluate care coordination activities delivered to Centennial Care enrollees, both members transitioning from Salud and CoLTS programs and new members covered under Centennial Care. It calculates the percentages based on: • A Q4 cumulative total of HRAs completed compared to the number of HRAs required for transition members • The number of HRAs completed during the quarter compared to the number of HRAs required for new members • The number of HRAs completed within 30 days of enrollment compared to those completed during the quarter for new members • HSD agreed to use the timeline of "during the quarter" and "within 30 calendar days of enrollment" reported by the MCOs as surrogates for "within contract timelines" listed in the Evaluation Plan.	DY1 to DY2	HSD furnished Deloitte with HSD 6 reports containing counts of HRAs required and completed for transition and new Medicaid members in each year. For the percentage of required HRAs completed for transition members within the quarter, Deloitte summed the fourth quarter cumulative counts of HRAs completed by transition members as well as the fourth quarter cumulative counts of HRAs required for transition members across MCOs then divided the former by the latter for each year. For the percentage of required HRAs completed for new members during the quarter, Deloitte summed quarterly counts of HRAs completed for new members as well as quarterly counts of HRAs required for new members across MCOs then divided the former by the latter for each year. For the percentage of required HRAs completed within 30 days of enrollment for new members, Deloitte summed quarterly counts of HRAs completed within 30 days of enrollment for new members across MCOs then divided that by the sum of the number of HRAs completed for new members previously calculated. PHP did not report a rate for HRAs completed for transition members in DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
29	Number and percentage of participants who received a care coordination designation and assignment of care coordinator within contract timeframes.	"Number and Percentage of those Provided Care Coordination Level Assignment Package within 10 Calendar Days of HRA" is a measure developed by HSD as a way to evaluate the timeliness of care coordination activities delivered to members covered under Centennial Care. The data elements required for this measure are not included in the HSD Care Coordination reports, therefore, HSD agreed to use the metric "Number of Medicaid Members who were Provided Care Coordination Level Assignment Package within 10 Calendar Days of HRA" as an alternative definition based on the assumption that if a member receives a care coordination packet, then the MCO would have also designated the member to care coordination and assigned a care coordinator.	DY1 to DY2	HSD furnished Deloitte with HSD 6 reports containing quarterly counts of members that received care coordination level assignment packages within 10 days of HRA. Numerators and denominators were developed by summing the quarterly counts across MCOs.
30	Number and percentage of participants in care coordination Level 2 that had comprehensive needs assessments scheduled and completed within contract timeframes	"Number and Percentage of Participants in Care Coordination Level 2 Based on the Comprehensive Needs Assessment" is a measure developed by HSD as a way to evaluate the timeliness of care coordination activities delivered to Centennial Care enrollees, both members transitioning from Salud and CoLTS programs and new members covered under Centennial Care. However, the data elements required to measure this activity were not included in HSD reports, including "within contract timelines." An alternative definition was developed to align the intent of the Evaluation Plan with the information available in HSD Care	DY1 to DY2	HSD furnished Deloitte with HSD 6 reports containing quarterly counts of Level 2 assignments given and CNAs completed for both transition and new members during the quarter. Numerators and denominators were developed by summing the fourth quarter counts across MCOs. PHP did not report data for transition members in DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
		Coordination Report 6: The "Number and Percentage of Level 2 Assignments Based on the CNA." Measure calculated using "Level 2 Assignments based on the CNA as a percentage of the CNAs completed for both transition and new members.		
31	Number and percentage of participants in care coordination Level 3 that had comprehensive needs assessments scheduled and completed within contract timeframes	"Number and Percentage of Participants in Care Coordination Level 3 Based on the Comprehensive Needs Assessment" is a measure developed by HSD as a way to evaluate the timeliness of care coordination activities delivered to Centennial Care enrollees, both members transitioning from Salud and CoLTS programs and new members covered under Centennial Care. However, the data elements required to measure this activity were not included in HSD reports, including "within contract timelines." An alternative definition was developed to align the intent of the Evaluation Plan with the information available in HSD Care Coordination Report 6: The "Number and Percentage of Level 3 Assignments Based on the CNA." Measure calculated using "Level 3 Assignments based on the CNA as a percentage of the CNAs completed for both transition and new members.	DY1 to DY2	HSD furnished Deloitte with HSD 6 reports containing quarterly counts of Level 3 assignments given and CNAs completed for both transition and new members during the quarter. Numerators and denominators were developed by summing the fourth quarter counts across MCOs. PHP did not report data for transition members in DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
32	Number and percentage of participants in care coordination Level 2 who received in-person visits and telephone contact within contract timeframes	"Number and Percentage of Participants in Care Coordination Level 2 Who Received In-Person Visits and Telephone Contact within Contract Timeframes" is a measure developed by HSD as a way to evaluate care coordination activities delivered to Centennial Care enrollees, both members transitioning from Salud and CoLTS programs and new members covered under Centennial Care. This measure is calculated using: • Number of Level 2 members who completed semi-annual in person visit this quarter compared to the number of Level 2 members who required semi-annual in person visit this quarter • Number of Level 2 members who completed quarterly telephone contacts this quarter compared to the number of Level 2 members who required quarterly telephone contacts this quarter HSD agreed to use required "semiannual visits" and "quarterly telephone contact" listed in HSD Report 6 as the timelines that fulfill "contract timelines" listed in the Evaluation Plan.	DY1 to DY2	HSD furnished Deloitte with HSD 6 reports containing quarterly counts of members that received in-person visits and telephone contact as well as the number of in-person visits and telephone contacts required for the quarter. Numerators and denominators were developed by summing the quarterly counts across MCOs. PHP did not report data for transition members in DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
33	Number and percentage of participants in care coordination Level 3 who received in-person visits and telephone contact within contract timeframes	"Number and Percentage of Participants in Care Coordination Level 3 Who Received In-Person Visits and Telephone Contact within Contract Timeframes" is a measure developed by HSD as a way to evaluate care coordination activities delivered to Centennial Care enrollees This measure is calculated using: • Number of Level 3 members who completed quarterly in person visit during the quarter compared to the number of Level 3 members who required quarterly in person visits during the quarter • Number of Level 3 members who completed monthly telephone contacts during the quarter compared to the number of Level 3 members who required monthly telephone contacts during the quarter HSD agreed to use required "quarterly visits" and "monthly telephone contact" listed in HSD Report 6 as the timelines that fulfill "contract timelines" listed in the Evaluation Plan.	DY1 to DY2	HSD furnished Deloitte with HSD 6 reports containing quarterly counts of members that received in-person visits and telephone contact as well as the number of in-person visits and telephone contacts required for the quarter. Numerators and denominators were developed by summing the quarterly counts across MCOs.

Measure	Measure Name	Definition	Evaluation Methodology	
34	Number and percentage of participants the MCO is unable to locate for care coordination	"Number and Percentage of Participants the MCO is Unable to Engage for Care Coordination" is a measure developed by HSD as a way to evaluate care coordination activities delivered to Centennial Care enrollees. The data element specifically citing "unable to locate for care coordination" was not included in MCO reports, instead, MCOs reported the number of transition and new Medicaid members for whom a CNA was required but the MCO was "unable to engage." This differs from those members who refused a CNA which is reflected in measure 36. To calculate this measure, a four-quarter cumulative total for transition members and an annual total for new members was calculated.	DY1 to DY2	HSD furnished Deloitte with HSD 6 reports containing quarterly counts of members that the MCO was unable to engage during the quarter. Numerators and denominators were developed by summing the fourth quarter counts across MCOs. PHP did not report data for transition members in DY2.
35	Number and percentage of members transitioning from HCBS to a NF; number and percentage of participants in NF transitioning to community (HCBS)	"Number and Percentage of Participants in Nursing Facility (NF) Transitioning to Community (HCBS)" is a measure developed by HSD as a way to evaluate efforts to appropriately avoid nursing home admissions. The specific data elements required to measure this activity were not included in MCO reports; instead, MCOs reported the number of members who left a nursing facility and moved to the community and the number of members readmitted to a nursing facility during the quarter. Therefore, an alternative definition was developed to align the	DY1 to DY3	HSD furnished Deloitte with HSD 7 reports containing quarterly counts of unique members in NF, members that left NF and moved to community, and members readmitted to NF during the quarter. Numerators and denominators were developed by summing the quarterly counts across MCOs.

Measure	Measure Name	Definition	Evaluation Methodology	
		intent of the Evaluation Plan with the information available in HSD Care Coordination Report 7. The data contained in the plans' reporting of these data points under the assumption that moving to the community from a NF means members will require HCBS. HSD also agreed to use NF readmissions (as a percentage of members transitioned to the community) as an alternative for "members transitioning from HCBS to a NF".		
36	Number and percentage of participants who refuse care coordination	"Number and Percentage of Participants who Refused Care Coordination" is a measure developed by HSD as a way to evaluate care coordination activities delivered to Centennial Care enrollees. The specific data element required to measure this activity was not included in MCO reports, instead, MCOs reported the number of transition and new Medicaid members who "refused a CNA," based on the assumption that if the member refused the process to screen for care coordination, then they would also refuse to participate in care coordination. To calculate this measure, a four-quarter cumulative total for transition members and an annual total for new members was calculated as a percentage of the number of CNAs required for Medicaid members.	DY1 to DY2	HSD furnished Deloitte with HSD 6 reports containing quarterly counts of members that the MCO was unable to engage during the quarter. Numerators and denominators were developed by summing the quarterly counts across MCOs. PHP did not report data for transition members in DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
37	EPSDT screening ratio	"EPSDT Screening Ratio" measures the actual number of screenings children under the age of 21 were provided with against the number of screenings that all children enrolled in Medicaid should have received. Each state that supervises or administers a medical assistance program under Title XIX of the Social Security Act must report annually on form CMS-416. The actual number of screenings is based on the number of initial and periodic screening services required by the state's periodicity schedule and prorated by the proportion of the year for which they were EPSDT eligible. The information is used to assess the effectiveness of state EPSDT programs in terms of the number of individuals under the age of 21 (by age group and basis of Medicaid eligibility) who are provided child health screening services. To be counted under this measure, members must have been enrolled for at least 90 continuous days during the reporting period. The EPSDT Screening Ratio is one of several measures required to be included in the federally required Annual EPSDT Participation Report (Form CMS-416). The CMS-416 Report provides basic information on participation in the Medicaid child health program.	FFY 2013 Baseline to FFY 2015	HSD furnished Deloitte with CMS-416 reports for each FFY that contained a combined EPSDT screening ratio for the four MCOs participating in Centennial Care. For the national comparison rate, the CMS-416 Annual EPSDT Participation Report for FFY 2015 was used.

Measure	Measure Name	Definition	Evaluation Methodology	
38	Annual monitoring for patients on persistent medications	"Annual Monitoring for Patients on Persistent Medications" is a HEDIS measure that reports the percentage of members 18 years and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year, and received at least one therapeutic monitoring event for the therapeutic agent in the measurement year: • Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB) • Annual monitoring for members on digoxin • Annual monitoring for members on diuretics • Total rate (sum of the three numerators divided by the sum of the three denominators) To be counted towards this measure, members may not have more than one gap in enrollment of up to 45 days during the measurement year. In addition, members must have had at least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year. For the digoxin measure, members must have had at least one serum potassium, at least one serum creatinine, and at least one serum digoxin therapeutic monitoring test in the measurement year. Adverse	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		drug events contribute to patient injury and increased health care costs. For patients on persistent medications, appropriate monitoring can reduce the occurrence of preventable adverse drug events. This HEDIS measure evaluates whether adult members receiving medication therapy were monitored while on the medication.		
39	Medication management for people with asthma	"Medication Management for People with Asthma" is a HEDIS measure that reports the percentage of adults and children 5 – 64 years of age during the measurement year who were identified as having persistent asthma and who were dispensed an asthma controller medication that they remained on for at least 50% of their treatment period. The prevalence and cost of asthma have increased over the past decade, demonstrating the need for better access to care and medication. Appropriate medication management for patients with asthma could reduce the need for rescue medication—as well as the costs associated with ER visits, inpatient admissions and missed days of work or school.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate. For the national comparison rate, Deloitte used the 2016 National Medicaid MCO rate as reported by NCQA in "The State of Health Quality – 2016." The 2016 national rate represents activity in 2015.
40	Asthma medication ratio	"Asthma Medication Ratio" is a HEDIS measure that reports the percentage of adults and children 5 – 64 years of age who were identified as having persistent asthma and who had a ratio of controller medications to total asthma medications of 0.50 or greater during	Baseline – DY2	HSD furnished Deloitte with HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting

Measure	Measure Name	Definition	Evaluation Methodology	
		the measurement year. The NCQA reports an overall ratio, as well as a separate ratio for children age 5 – 11, children age 12 – 18, adults age 19 – 50, and adults age 51 – 64. The Asthma Medication Ratio evaluates whether people diagnosed with persistent asthma were adequately using controller medications.		the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
41	Adult BMI assessment and weight assessment for children/adolescents	"Adult BMI Assessment" is a HEDIS measure that reports the percentage of adults 18 – 74 years of age who had an outpatient visit and whose BMI was documented in the past two years. "Weight Assessment for Children/Adolescents" is a HEDIS measure that reports the percentage of children and adolescents 3 – 17 years of age who had an outpatient visit with a primary care practitioner or OB/GYN during the measurement year and who had evidence of: • BMI percentile documentation • Counseling for nutrition • Counseling for physical activity "Obesity" is defined as an amount of body fat higher than what is considered healthy for an individual's weight. Obesity contributes to nearly one in five deaths in the United States. Obesity ranges are determined by using a commonly used weight-for-height screening tool called the "BMI", which	Baseline to DY2	HSD furnished Deloitte with HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		correlates with the amount of body fat. BMI provides the most useful population-level measure of overweight and obesity. The Adult BMI Assessment rate is based on the assumption that careful monitoring of BMI will help health care providers identify adults who are at risk and provide focused advice and services to help them reach and maintain a healthier weight. The Weight Assessment for Children/Adolescents measure recognizes that obesity can become a lifelong health issue; therefore, it is important to monitor weight problems in children and adolescents under the age of 18 and provide guidance for maintaining a healthy weight and lifestyle.		
42	Comprehensive diabetes care	"Comprehensive Diabetes Care" is a HEDIS measure defined as the percentage of adults 18 – 75 years of age with diabetes (Type One or Type Two) who had each of the following: • Hemoglobin A1c (HbA1c) testing • HbA1c poor control (>9.0%) • HbA1c control (<8.0%) • Eye exam (retinal) performed • Medical attention for nephropathy • BP control (<140/90 mm Hg) A separate rate is reported for each of the six factors included in the above	Baseline to DY2	HSD furnished Deloitte with HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		measure definition. One additional rate associated with this measure, HbA1c Control (<7.0%) for a Selected Population, was not reported by any of the MCOs in either any reported data year.		
43	Ambulatory Care Sensitive admission rates: diabetes short and long term complications, uncontrolled admission rates	The "ACS Diabetes Short-Term Complications Admission Rate (PQI-01)" is defined as the number of inpatient hospital admissions for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 enrollee months for Medicaid enrollees ages 18 years and older. The "ACS Diabetes Long-Term Complications Admission Rate (PQI-03)" is defined as the number of admissions for a principal diagnosis of diabetes with long-term complications (renal, eye, neurological, circulatory, or complications not otherwise specified) per 100,000 Medicaid enrollees 18 years and older. Both measures are PQI measures sponsored by the AHRQ. The PQIs are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early	Baseline	For the baseline calculation, HSD furnished Deloitte with two MMIS reports (Diabetes Short Term and Long Term Complications) containing combined numerator and denominator counts for the four MCOs contracted under the Salud! program and two MCOs contracted under the CoLTS program for CY 2013 for Claims Type A and Claims Type I. For each report, the numerator and denominator counts for both claims types were combined and a combined rate per 100,000 was calculated. Separate short-term diabetes complication admission rates were calculated for members 18 – 64 years of age and members age 65 and over. Long-term diabetes complication admission rates were aggregated for all members 18 years and older.

Measure	Measure Name	Definition	Evaluation Methodology	
		intervention can prevent complications or more severe disease. The PQIs are population based and adjusted for covariates. With high-quality, community based primary care, hospitalization for these illnesses often can be avoided. The PQIs provide a good starting point for assessing quality of health services in the community. To be counted in the numerator for the ACS Diabetes Short-Term Complications Admission Rate, members must be 18 years and older and have had an admission during measurement year for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma). To be counted in the numerator for the ACS Diabetes Long-Term Complications Admission Rate, members must be 18 years and older and have had an admission during the measurement year for a principal diagnosis of diabetes with long-term complications (renal, eye, neurological, circulatory, or complications not otherwise specified). For both measures, the denominator consists of all members 18 years and older. The measure is reported as a rate per 100,000.	DY1 to DY2	HSD furnished Deloitte with two reports based on encounters (i.e., PQI report for Diabetes Short Term and MMIS ad hoc report for Long Term Complications) containing combined numerator and denominator counts for the four MCOs contracted under Centennial Care. For each report, the numerator and denominator counts for both claims types were combined and a combined rate per 100,000 was calculated. Separate short-term diabetes complication admission rates were calculated for members 18 – 64 years of age and members age 65 and over. Long-term diabetes complication admission rates were aggregated for all members 18 years and older.

Measure	Measure Name	Definition	Evaluation Methodology	
44	Ambulatory care sensitive admission rates for COPD or asthma in older adults; asthma in younger adults	The "Asthma in Younger Adults Admission Rate (PQI-15)" is defined as the number of inpatient hospital admissions for asthma per 100,000 enrollee months for Medicaid enrollees 18 – 39 years of age. The "COPD or Asthma in Older Adults Admission Rate (PQI-05)" is defined as the number of inpatient hospital admissions for COPD or asthma per 100,000 enrollee months for Medicaid enrollees 40 years and older. Both measures are PQI measures. To be counted in the "Asthma in Younger Adults Admission Rate" measure, members must be 18 – 39 years of age and have had an admission during the measurement year for a principal diagnosis of asthma, excluding admissions with an indication of cystic	Baseline	HSD furnished Deloitte with two MMIS reports (i.e., Asthma in Younger Adults and COPD or Asthma in Older Adults) containing combined numerator and denominator counts for the four MCOs contracted under the Salud! program and two MCOs contracted under the CoLTS program for CY 2013 for Claims Type A and Claims Type I. For each report, the numerator and denominator counts for both claims types were combined and a combined rate per 100,000 was calculated.

Measure	Measure Name	Definition	Evaluation Methodology	
		fibrosis or anomalies of the respiratory system, obstetric admissions, and transfers from other institutions. To be counted in the "COPD or Asthma in Older Adults Admission Rate" measure, members must be 40 years and older and have had an admission with a principal diagnosis of COPD or asthma, excluding obstetric admissions and transfers from other institutions. To be included in the denominator, members must have been enrolled on the last day of the measurement year and must not have had more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a one-month gap in coverage.	DY1 to DY2	HSD furnished Deloitte with two MMIS reports (i.e., Asthma in Younger Adults and COPD or Asthma in Older Adults) containing combined numerator and denominator counts for the four MCOs contracted under the Centennial Care program for Claims Type A and Claims Type I. For each report, the numerator and denominator counts for both claims types were combined and a combined rate per 100,000 was calculated.
45	Ambulatory care sensitive admission rates for hypertension	The "ACS Admission Rate for Hypertension (PQI-7)" is defined as the number of inpatient hospital admissions with a principal diagnosis of hypertension per 100,000 enrollee months for Medicaid enrollees 18 years and older. The measure excludes kidney disease combined with dialysis access procedure admissions, cardiac procedure admissions, obstetric admissions, and transfers from other	Baseline	For the baseline calculation, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs contracted under the Salud program and two MCOs contracted under the CoLTS program for CY 2013 for Claims Type A and Claims Type I. The numerator and denominator counts for both claims types were combined and a combined rate per 100,000 was calculated.

Measure	Measure Name	Definition	Evaluation Methodology	
		institutions. The measure is a PQI measure. To be counted under this measure, members must have been enrolled on the last day of the measurement year and must not have had more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a one-month gap in coverage.	DY1 to DY2	For DY1 to DY2, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs participating in Centennial Care. The numerator and denominator counts for both claims types were combined and a combined rate per 100,000 was calculated.
46	ACS admission rates for pediatric asthma	Evaluates the number of inpatient hospital admissions per 100,000 member months with a principal diagnosis of asthma in children 2 – 17 years of age. The measure excludes cases with a diagnosis code for cystic fibrosis and anomalies of the respiratory system, obstetric admissions, and transfers from other institutions.	Baseline to DY2	The unique managed care encounter claim count is summed across MCOs and divided by the member month count (also summed across MCOs) as a denominator.
47	Number and percentage of potentially avoidable ER visits	The "Number and Percentage of Potentially Avoidable ER Visits" examines the number and percentage of unduplicated members with an ER visit for a non-emergent condition relative to the number of unduplicated members with an ER visit for any reason. This measure applies to any member who presents at an ER, has a claim is submitted and for which the condition is non-emergent. Per the Centennial Care contract, an emergency medical condition means a medical or behavioral health condition manifesting itself through acute	DY1 to DY2	The MCOs under the Salud and CoLTS programs did not report on this measure in 2013. Therefore, 2014 data will be utilized as the baseline. HSD furnished Deloitte with MCO reports (HSD 40: Over-Under Utilization Report) submitted by three of the four MCOs (MHC did not have reportable data in 2014 or 2015). The reports covered the four quarters of their respective calendar years (DY1 and DY2) and contained the total number of unduplicated members by care coordination levels one through seven. To calculate the percent of potentially avoidable ER visits in each year, Deloitte combined the three plans' total number of unduplicated members with

Measure	Measure Name	Definition	Evaluation Methodology	
		symptoms of sufficient severity (including severe pain) such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: (i) placing the members' health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; (iii) serious dysfunction of any bodily organ or part; or (iv) serious disfigurement to the member. Conditions that do not meet the criteria of an emergency medical condition are considered to be potentially avoidable ER visits. This measure examines potentially avoidable ER visits per care coordination level and in total. MCOs are also required to identify the 10 most frequent ICD codes for members with non-emergent ER visits during the quarterly reporting period.		an ER visit for non-emergent conditions and divided this by the total number of unduplicated members with an ER visit for any condition.
48	Medical assistance with smoking and tobacco use cessation	"Medical Assistance with Smoking and Tobacco Use Cessation" is a HEDIS measure that uses survey data to assess the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit smoking during the measurement year. This measure is one component of a three-part CAHPS survey measure that assesses different facets of providing medical assistance	Baseline	HSD furnished Deloitte with CY 2013 CAHPS data for three of the four MCOs contracted under the Salud program and one of the two MCOs contracted under the CoLTS program. The total enrollment in 2013 of the four plans represented 75% of total combined Salud/CoLTS membership. Deloitte took an unweighted average of each plan's summary rate (which is a two-year rolling average for smoking cessation measures) for each subcomponent.

Measure	Measure Name	Definition	Evaluation Methodology	
		with smoking and tobacco cessation. The three components include: • Advising Smokers and Tobacco Users to Quit • Discussing Cessation Medications • Discussing Cessation Strategies.	DY1 to DY2	HSD furnished Deloitte with CY 2014 and CY 2015 CAHPS data for the four Centennial Care MCOs. Deloitte took an unweighted average of each plan's summary rate (again, a two-year rolling average) to compute the aggregate rate for each subcomponent.
49	Number of critical incidents by reporting category	The "Number of Critical Incidents by Reporting Category" measure determines the number and percentage of critical incidents reported in the following categories: • Abuse; • Neglect; • Exploitation; • Environmental hazard; • Emergency services; • Law enforcement; • Elopement/missing; and • Death (Natural/expected; Unexpected; Homicide; and Suicide). The standard definition of a "critical incident" is "an occurrence that represents actual or potential serious harm to the well-being of a member or to others by members." A reportable incident for the behavioral health provider community is defined as "any known, alleged or suspected event of abuse, neglect, exploitation, injuries of	DY1 to DY2	The MCOs under the Salud and CoLTS programs did not report on this measure in 2013. Therefore, calendar year 2014 data will be utilized as the baseline. HSD furnished Deloitte with critical incident reports submitted for the four MCOs. The reports covered the 12 months of each year. The results are aggregated across MCOs by incident category for the purposes of reporting. Results are presented separately for Centennial Care total, Behavioral Health, and Self-directed.

Measure	Measure Name	Definition	Evaluation Methodology	
		unknown origin, death, environmental hazard, which involve some level of reporting or intervention with other state or service entities including law enforcement, crisis or emergency services, and present actual or potential serious harm to the well-being of a consumer or to others by the consumer. MCOs are required to submit critical incident reports on a quarterly basis. Each contracted MCO has access to the web-based Critical Incident Reporting System. MCO access to the website includes access to all critical incident reports submitted by the MCO. It also includes all critical incidents submitted by providers of authorized services for the members of that MCO.		
50	Antidepressant medication management	"Antidepressant Medication Management" is a HEDIS measure defined as the percentage of adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on an antidepressant medication treatment. Two rates are reported: • Effective Acute Phase Treatment; and • Effective Continuation Phase Treatment. This measure recognizes that effective medication treatment of major depression can improve a person's daily	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		functioning and well-being, and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated as well. To be included in the numerator for the two measures, members must have received: • Effective Acute Phase Treatment: At least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114 -day period following the Index Prescription Start Date. • Effective Continuous Phase Treatment: At least 180 days (six months) of continuous treatment with antidepressant medication during the 231 day period following the Index Prescription Start Date. To be counted in the denominator, members must be 18 years of age and older as of April 30 of the measurement year, have a negative medication history, have a diagnosis of major depression during the intake period, and have been treated with antidepressant medication. Members must have been enrolled on the last day of the measurement year and must not have had more than one gap in enrollment of up to 45 days during each year of continuous enrollment.		

Measure	Measure Name	Definition	Evaluation Methodology	
51	Inpatient admissions to psychiatric hospitals and RTCs	The "Inpatient Admissions to Psychiatric Hospitals and RTCs" measure provides separate counts for the number of members admitted to either a psychiatric hospital or RTC. The counts may be duplicated when a member has multiple claims during the report period with different billing providers. This measure is based on the premise that effective care management should reduce the number of admissions through the use of appropriate early interventions. To be counted for the psychiatric hospital measure, members must have a paid claim type A or I for the measurement year for admission to a hospital, psychiatric unit within an acute care hospital, or a psychiatric hospital. To be counted for the RTC measure, members must have a paid encounter for admission to an RTC during the measurement year.	Baseline	For the baseline calculation, HSD furnished Deloitte with the Inpatient Admissions to Psychiatric Hospitals (Claims Type A and I) and Residential Treatment Centers Report for CY 2013, which was derived from MMIS data. The report contained data for the four MCOs contracted under the Salud program and two MCOs contracted under the CoLTS program. The total number of Paid Psychiatric Hospital encounters with a date of service in CY 2013 was reported. The total number of Paid Residential Treatment Center encounters with a date of service in CY 2013 was reported.
			DY1 to DY2	For DY1 to DY2, HSD furnished Deloitte with the Inpatient Admissions to Psychiatric Hospitals (Claims Type A and I) and Residential Treatment Centers Report, which was derived from claims data. The report data contained data submitted by the four MCOs.
52	Percentage of NF members who transitioned from a low NF to a high NF	The "Percentage of Nursing Facility Members Who Transitioned from a Low Nursing Facility to a High Nursing Facility" is intended to determine to what extent care management assists members in remaining in the least restrictive setting that meets their needs. This measure counts all Centennial Care members who were receiving either	DY1 to DY3	The MCOs did not report on this measure in 2013. Therefore, 2014 data is utilized as the baseline. HSD furnished Deloitte with HSD8 reports containing monthly data for the four Centennial Care plans in each year. Deloitte took the sum of all 12 months of data of members in high and low nursing facilities and combined this number into a denominator. The counts of high and low nursing facility enrollees were divided by this denominator to get a rate for each MCO. These numerators were

Measure	Measure Name	Definition	Evaluation Methodology	
		high or low nursing facility services during one or more months of calendar year 2014.		summed and divided by the denominators for an aggregate rate in each calendar year.
53	Fall risk intervention	The percentage of members 65 years of age and older who have had a fall or problem with balance in the 12 months prior to the measurement date, who were seen by a practitioner during that same time period, and who received a fall risk intervention. This HEDIS measure is collected using the Medicare Health Outcome Survey (HOS). The two components of this survey measure assess different facets of fall risk management: discussing fall risk and managing fall risk.	DY1 to DY2	HSD furnished Deloitte with ad hoc reports containing the FRM rates and denominators for each year.
54	Percentage of the population accessing both a behavioral health service and a PCP visit in the same year	The "Percentage of the Population Accessing both a Behavioral Health Service and a PCP Visit in the Same Year" is defined as the percentage of the entire managed care population that accessed both a behavioral health service (defined by provider types and/or services on the claim) and at least one PCP visit during the measurement year. To be counted under this measure, members must have been enrolled on the last day of the measurement year. This measure examines the percentage of unduplicated members with at least one PCP visit. The numerator is the number of members (any age) that accessed both a behavioral health service and at least on PCP visit in the same year. The denominator is the entire managed care population.	Baseline	For the baseline calculation, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs contracted under the Salud! program and two MCOs contracted under the CoLTS program for the baseline.
			DY1 to DY2	For DY1 and DY2, HSD furnished Deloitte with MMIS reports containing combined numerator and denominator counts for the four MCOs participating in Centennial Care.

Measure	Measure Name	Definition	Evaluation Methodology	
55	Percentage of population accessing an LTSS service that received a PCP visit in the same year	The "Percentage of the Population Accessing an LTSS Service and a PCP Visit in the Same Year" is defined as the percentage of the LTSS population that received at least one PCP visit during the measurement year. To be counted under this measure, members must have been enrolled on the last day of the measurement year. This measure examines the percentage of unduplicated members with at least one PCP visit. The numerator is the number of members (any age) that accessed at least one PCP visit in the year. The denominator is the LTSS population as defined by LTSS services received during the year.	Baseline	For the baseline calculation, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs contracted under the Salud! program and two MCOs contracted under the CoLTS program for the baseline.
			DY1 to DY3	For DY1 through DY3, HSD furnished Deloitte with MMIS reports containing combined numerator and denominator counts of unique individuals that accessed the specified services for the four MCOs participating in Centennial Care.
56	Percentage of participants who accessed an LTSS service and a behavioral health visit in the same year	The "Percentage of the Population Accessing an LTSS Service and a Behavioral Health Visit in the Same Year" is defined as the percentage of the entire managed care population that accessed both an LTSS service and a behavioral health visit during the measurement year. The population accessing LTSS is defined as: members who are nursing facility level of care; members who are dually eligible for Medicare and Medicaid; members are developmentally disabled or medically fragile and who	Baseline	For the baseline calculation, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs contracted under the Salud! program and two MCOs contracted under the CoLTS program for 2013.

Measure	Measure Name	Definition	Evaluation Methodology	
		are in the Mi Via Self-Directed Waiver; members with HIV/AIDs; and members who are in the physically disabled or frail elderly category. To be counted under this measure, members must have been enrolled on the last day of the measurement year. The numerator is the number of members (any age) that accessed an LTSS service and a behavioral health service in the same year. The denominator is the entire managed care population.	DY1 to DY3	For DY1 through DY3, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs participating in Centennial Care.
57	Percentage of population with behavioral health needs with an ER visit by type of ER visit	The percentage of the Centennial Care population with behavioral health needs that has any type of ER visit with a behavioral health diagnosis during the measurement year, which is broken down by the following types of ER visits: • Emergency Medical Treatment and Labor Act (EMTALA) • Urgent care • Limited to minor • Low to moderate • Moderate • High severity • Life threatening • Admitted through the ER	Baseline to DY2	HSD furnished Deloitte with MMIS reports containing a count of the behavioral health needs and all emergency department visits for each type of ER visit. This count is then divided by the total behavioral health needs population for a rate for each type of visit.

Measure	Measure Name	Definition	Evaluation Methodology	
58	Percentage of the population with LTSS needs with an ER visit by type of ER visit	The percentage of the Centennial Care population with LTSS needs that has any type of ER visit during the measurement year, which is broken down by the following types of ER visits: • EMTALA • Urgent care • Limited to minor • Low to moderate • Moderate • High severity • Life threatening • Admitted through the ER	Baseline to DY2	HSD furnished Deloitte with MMIS reports containing a count of the LTSS needs and all emergency department visits for each type of ER visit. This count is then divided by the total LTSS needs population for a rate for each type of visit.
59	Percentage of the population at risk for nursing facility placement who remain in the community	The "Percentage of the Population at Risk for Nursing Facility Placement Who Remain in the Community" is defined as the number of consumers who transition from nursing facilities and who are served and maintained with community-based services for six months. This measure is intended, for future years, to determine whether there are trends identified in the number of members who transition from nursing facilities and who are served in the community. Members with LTSS needs who receive care coordination services should be able to remain safely in their homes as an alternative to nursing home care. This outcome is desirable both from a quality-of-life perspective for members	Baseline	For the baseline calculation, HSD furnished Deloitte with the HSD Medical Assistance Division (MAD) Fourth Quarter SFY 14 HSD Performance Measures Report. The MAD report contained the quarterly and annual numbers of members who transition from nursing facilities and who are served and maintained with community-based services. The reports covered the 12 months of SFY 2013 for the two MCOs contracted under the CoLTS program. The report was derived from quarterly MMIS reports containing the number and service longevity of members who transitioned from a nursing facility into a community-based service. The MMIS reports are run 30 days after the end of each quarter. The total number of members who transitioned into community services is current with the last month of each quarter when reported, but the number maintained for six months has a nine month reporting lag.

Measure	Measure Name	Definition	Evaluation Methodology	
		and also from a cost-effectiveness perspective for the state. The numerator for this measure is the number of members who receive community-based services for six or more months without a readmission to a nursing facility.	DY1 to DY2	For DY1 and DY2, HSD furnished Deloitte with the HSD Medical Assistance Division (MAD) Fourth Quarter SFY 15 HSD Performance Measures Report. The reports covered the 12 months of SFY 2014 and SFY 15, which included six months of data for the four MCOs participating in Centennial Care.
60	Number and percentage of participants who accessed a behavioral health service that also accessed HCBS	The "Number and percentage of Members Who Accessed a Behavioral Health Service That Also Accessed HCBS in the Same Year" is defined as the percentage of the entire managed care population that accessed both a behavioral health service and HCBS during the measurement year. The population accessing HCBS is defined as all members who are enrolled in managed care who accessed both a behavioral health and HCBS service.	Baseline	For the baseline calculation, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs contracted under the Salud! program and two MCOs contracted under the CoLTS program for CY 2013.

Measure	Measure Name	Definition	Evaluation Methodology	
		Under Centennial Care, these members include individuals who are enrolled in the Developmentally Disabled waiver or the Medically Fragile waiver. To be counted under this measure, members must have been enrolled on the last day of the measurement year. The numerator is the number of members (any age) that accessed a behavioral health service and HCBS in the same year. The denominator is the entire managed care population.	DY1 to DY3	For DY1 through DY3, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs participating in Centennial Care.
61	Number and percentage of members that maintained their care coordination level, moved to a lower care coordination level, or moved to a higher care coordination level	The "Number and Percentage of Members Who Maintain Their Care Coordination Level or Move to a Different Level" measure determines the number and percentage of members receiving care coordination services who: • Remain at their current level - The number of unduplicated active members who are receiving Care Coordination as of the last day of the reporting period and are assigned the same Care Coordination Level (CCL2 or CCL3) as of the last day of the prior reporting period; • Move to a lower level - the number of unduplicated active members who, as a result of a CNA, are determined to no longer meet the requirements for CCL3 but still meet the requirements of CCL2 during the month reporting period; plus the number of unduplicated active members who, as a result of a CNA, are determined to no longer	DY1 to DY3	HSD furnished Deloitte with ad hoc care coordination reports for the four MCOs for each year. The membership counts are reported by month, and Deloitte averaged the monthly count for each MCO and combined the four plans' numerator and denominator values to calculate an average aggregate rate for each year. The counts presented in the exhibit are the average member months, or an estimate for unduplicated member counts over the measurement year.

Measure	Measure Name	Definition	Evaluation Methodology	
		meet the requirements for CCL2 during the monthly reporting period but were receiving CCL2 as of the last day of the prior monthly reporting period on the last day of the reporting period, the members is no longer receiving Care Coordination; and • Move to a higher level - The number of unduplicated active members who, as a result of a CNA, are determined to meet the requirements for CCL2 during the monthly reporting period. On the last day of the prior reporting period the member was enrolled but not receiving Care Coordination; plus, the number of unduplicated active members who, as a result of a CNA, were determined to meet the requirements for CCL3 during the monthly reporting period. On the last day of the prior reporting period, the member was enrolled, but either receiving CCL2 or was not receiving Care Coordination.		

Measure	Measure Name	Definition	Evaluation Methodology	
62	Percentage of population accessing a behavioral health service that received an outpatient ambulatory visit in the same year	The "Percentage of the Population Accessing a Behavioral Health Service That Received an Outpatient Ambulatory Visit in the Same Year" is defined as the percentage of the entire managed care population that accessed both a behavioral health service and an outpatient ambulatory visit during the measurement year, based on a review of provider IDs and procedure codes found on the claims. To be counted under this measure, members must have been enrolled during the measurement year. The numerator is the number of members (any age) that accessed both a behavioral health service and an outpatient ambulatory visit in the same year. The denominator is the entire managed care population.	Baseline	For the baseline calculation, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs contracted under the Salud! program and two MCOs contracted under the CoLTS program.
			DY1 to DY2	For DY1 through DY2, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs participating in Centennial Care.
63	Diabetes screening for members with schizophrenia or bipolar disorder who are using antipsychotic medications	"Diabetes Screening for Members with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications" is a HEDIS measure defined as the percentage of members 18 – 64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. To be counted under this measure, members must have been continuously enrolled during the measurement year and must not have had more than one gap in enrollment of up to 45 days	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a one-month gap in coverage. The denominator for this measure includes members 18 – 64 years of age by December 31 of the measurement year who have schizophrenia or bipolar disorder who were dispensed an antipsychotic medication. The numerator consists of members who had a glucose test or an HbA1c test performed during the measurement year.		
64	Diabetes monitoring for members with diabetes and schizophrenia	"Diabetes Monitoring for Members with Diabetes and Schizophrenia" is a HEDIS measure defined as the percentage of members 18 – 64 years of age with diabetes and schizophrenia who had both a low-density lipoprotein cholesterol (LDL-C) test and an HbA1c test during the measurement year. To be counted under this measure, members must have been continuously enrolled during the measurement year and must not have had more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a one month gap in coverage.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		The denominator for this measure includes members 18 – 64 years of age as of December 31 of the measurement year with schizophrenia and diabetes. The numerator consists of members who had an HbA1c test and an LDL-C test performed during the measurement year.		
65	Total program expenditures	"Total Program Expenditures" is intended to summarize all costs of providing services to eligible Medicaid beneficiaries enrolled in the Centennial Care program, including: • Total computable costs of providing Medical Assistance Program services to the populations covered under Centennial Care, • Tracked and recorded uncompensated care costs of approximately $68.9 million, and • Fee-for-service, managed care, and other associated costs for the covered Native American Indian population.	Baseline	HSD furnished Deloitte with the quarterly CMS-64 Schedule C expenditure reports as well as the quarterly Centennial Care reports submitted to CMS which summarize member months by MEG each quarter. Deloitte calculated a baseline program cost for each MEG using the respective member months from the quarterly reports HSD submitted to CMS and the estimated per-member per-month (PMPM) costs without waiver thresholds set under STCs 106 – 108. Per STCs 106 – 108, these cost thresholds were defined for each of the six MEGs covered under Centennial Care and vary annually for the five years of the waiver demonstration. The member months from HSD's quarterly reports were used to convert the PMPM cost thresholds from STCs 106 – 108 into total program expenditures.
			DY1 to DY3	The total program costs for each year as provided in the CMS-64 Schedule C reports.

Measure	Measure Name	Definition	Evaluation Methodology	
66	Costs per member	The "Costs per Member" measure is the per-member per-month cost calculated as the total expenditure of each MEG divided by the corresponding total member months of that MEG.	Baseline	The baseline PMPMs were taken directly from STCs 106 – 108 for each MEG.
			DY1 to DY3	The PMPM cost for each MEG were calculated by using the total program costs for each year as tracked in measure 65 divided by the member months provided in each of the quarterly Centennial Care submissions to CMS.
67	Costs per user of services	The "Costs per User of Services" measure is a per-user per-month representation of the total expenditures reported from Measure 65.	Baseline	Deloitte received an MMIS data extraction from HSD which calculated the number of Centennial Care members with paid capitation and a service encounter in the same month, for each month. The user PMPM without waiver is calculated by multiplying the estimated PMPM by MEG from the STCs by the given member months divided by their corresponding user member months.

Measure	Measure Name	Definition	Evaluation Methodology	
			DY1 to DY3	The PMPM cost for each MEG were calculated by using the total program costs for each year as tracked in measure 65 divided by the number of users by MEG provided in the MMIS data extraction described above.

Measure	Measure Name	Definition	Evaluation Methodology	
68	Utilization by category of service	"Utilization by Category of Service" tracks the utilization of selected services for physical health, behavioral health, and long term services and supports.	Baseline	The utilization across various service categories were reported in quarterly MCO financial submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. The reported utilization units were divided by annualized member months found in the same quarterly submissions to report the sub-measures on a "units per 1,000" basis. For certain measures where applicable, the average length of stay was calculated as days per admit. The baseline utilization measures are based on the first quarter reported utilization from the MCO submissions, divided by the member months as of the first quarter of DY1, and scaled to an annual units per 1,000 basis by multiplying by 12,000.
			DY1 to DY3	The annualized utilization rates in each year was calculated by summing the utilization units for the year and dividing by the total member months for the year. The measure was then scaled to an annual units per 1,000 basis by multiplying by 12,000.
69	Hospital costs	The "Hospital Costs" measure tracks the PMPM program expenditures of categories that are associated with	Baseline	The costs across various categories related to hospitals, clinics, and facilities, as well as member months, were reported in quarterly MCO financial

Measure	Measure Name	Definition	Evaluation Methodology	
		hospital, clinic, and facility visits. The categories of service included in hospital costs by program are: • PH: Inpatient Hospital – Acute, Inpatient - Specialty Hospital, Outpatient Hospital - Emergency Room, Outpatient Hospital - Urgent Care, Outpatient Facility – Other, Rural Health Clinics, FQHCs, Freestanding Clinics • BH: Outpatient Hospital (Evaluations, Therapies, and BH Physical Evaluations), Hospital Outpatient Facility (BH Treatment Services), Hospital Inpatient Facility (Psychiatric Hospitalization Services), Rural Health Clinics, FQHCs • LTSS: Nursing Facility State Owned - High Level of Care, Nursing Facility State Owned - Low Level of Care, Nursing Facility Private - High Level of Care, Nursing Facility Private - Low Level of Care, Nursing Facility Professional Charges, Other Nursing Facility Payments, Hospital Swing Bed - High Level of Care, Hospital Swing Bed - Low Level of Care, Inpatient Hospital – Acute, Inpatient - Specialty Hospital, Outpatient Hospital - Emergency Room, Outpatient Hospital - Urgent Care, Outpatient Facility – Other, Rural Health Clinics, FQHC's, Freestanding Clinics		submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. Reported costs from these files were aggregated on categories of service determined to be related to hospital services. For the baseline calculation, the hospital costs measure utilizes the sum of the costs for the hospital services reported in the first quarter of 2014 divided by the total member months in the same timeframe.
			DY1 to DY3	The annual PMPM for each demonstration year was calculated by summing the costs for the hospital services for the year and dividing by the total member months in the year.

Measure	Measure Name	Definition	Evaluation Methodology	
70	Use of HCBS	"Use of HCBS" tracks the utilization for Home and Community-Based Services (HCBS).	Baseline	The utilization for HCBS was reported in the quarterly MCO financial submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. For the baseline calculation, the use of HCBS measure utilizes the sum of the costs for the HCBS reported in the first quarter of 2014 divided by the total member months in the same timeframe, and scaled to an annual units per 1,000 basis by multiplying by 12,000.
			DY1 to DY3	The annualized rate for each demonstration year was calculated by summing the utilization units for the year and dividing by the same year's total member months. The measure was then scaled to an annual units per 1,000 basis by multiplying by 12,000.

Measure	Measure Name	Definition	Evaluation Methodology	
71	Use of institutional care (skilled nursing facilities)	The "Use of Institutional Care (Skilled Nursing Facilities)" measure tracks the utilization for non-acute long term care and skilled nursing services.	Baseline	The utilization for skilled nursing was reported in the quarterly MCO financial submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. The baseline utilization measure is based on the 2014 first quarter reported utilization from the MCO submissions, divided by the member months as of the first quarter of 2014, and scaled to an annual units per 1,000 basis by multiplying by 12,000.
			DY1 to DY3	The annualized rate for each demonstration year was calculated by summing the utilization units for the year and dividing by the same year's total member months. The measure was then scaled to an annual units per 1,000 basis by multiplying by 12,000.

Measure	Measure Name	Definition	Evaluation Methodology	
72	Use of mental health services	The "Use of Mental Health Services" measure tracks the utilization for behavioral health services and related facility visits.	Baseline	The utilization for mental health services was reported in the quarterly MCO financial submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. The baseline utilization measure is based on the 2014 first quarter reported utilization from the MCO submissions, divided by the member months as of the first quarter of 2014, and scaled to an annual units per 1,000 basis by multiplying by 12,000.
			DY1 to DY3	The annualized rate for each demonstration year was calculated by summing the utilization units for the year and dividing by the same year's total member months. The measure was then scaled to an annual units per 1,000 basis by multiplying by 12,000.

Measure	Measure Name	Definition	Evaluation Methodology	
73	Use of substance abuse services	"Use of Substance Abuse Services" tracks the utilization for methadone treatment.	Baseline	The utilization for substance abuse services was reported in the quarterly MCO financial submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. The baseline utilization measure is based on the 2014 first quarter reported utilization from the MCO submissions, divided by the member months as of the first quarter of 2014, and scaled to an annual units per 1,000 basis by multiplying by 12,000.
			DY1 to DY3	The annualized rate for each demonstration year was calculated by summing the utilization units for the year and dividing by the same year's total member months. The measure was then scaled to an annual units per 1,000 basis by multiplying by 12,000.

Measure	Measure Name	Definition	Evaluation Methodology	
74	Use of pharmacy services	This measure tracks the number of scripts per 1,000 for brand name, generic, and other drugs.	Baseline	The utilization for drug prescriptions services was reported in the quarterly MCO financial submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. The baseline utilization measure is based on the 2014 first quarter reported utilization from the MCO submissions, divided by the member months as of the first quarter of 2014, and scaled to an annual units per 1,000 basis by multiplying by 12,000.
			DY1 to DY3	The annualized rate for each demonstration year was calculated by summing the utilization units for the year and dividing by the same year's total member months. The measure was then scaled to an annual units per 1,000 basis by multiplying by 12,000.

Measure	Measure Name	Definition	Evaluation Methodology	
75	Inpatient services exceeding $50,000	"Inpatient Services Exceeding $50,000" tracks the annual cost of inpatient services exceeding $50,000 in a given calendar year. The measure is calculated in two ways; first, as the inpatient cost on a PMPM basis, and second, as a percentage of total health-related expenditures.	DY1 to DY3	High claims were reported in the quarterly MCO financial submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. To calculate the inpatient claims cost PMPM, the sum of the inpatient high cost claims were divided by the total member months as reported in the MCO quarterly submissions. To calculate the cost as a percentage of health-related expenditures, the sum of the claims was divided by total healthcare costs, not inclusive of administrative expenses. The baseline was determined using full DY1 experience since costs associated with inpatient services were tracked and reported on an aggregate, cumulative basis in the legacy programs (Salud!, CoLTS, and Behavioral Health).
76	Diagnostic Imaging Costs	The "Diagnostic Imaging Costs" measure tracks the PMPM costs associated with diagnostic imaging procedures. It was amended from its original measure, "Use of Diagnostic Imaging", as utilization data on diagnostic imaging was not available for DY1 for the purposes of tracking in this report. Deloitte will continue working with HSD to explore ways for diagnostic imaging utilization to be reported.	Baseline	The PMPM costs for diagnostic imaging were reported in the quarterly MCO financial submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. The baseline utilization measure is based on the 2014 first quarter reported utilization from the MCO

Measure	Measure Name	Definition	Evaluation Methodology	
				submissions, divided by the member months as of the first quarter of 2014.
			DY1 to DY3	The annualized rate for each demonstration year was calculated by summing the utilization units for the year and dividing by the same year's total member months.

Measure	Measure Name	Definition	Evaluation Methodology	
77	Emergency department use	"Emergency Department (ED) Use" tracks the utilization for ED visits for the physical health and LTSS services covered under the Centennial Care program.	Baseline	ED use was reported in the quarterly MCO financial submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. The baseline utilization measure is based on the 2014 first quarter reported utilization from the MCO submissions, divided by the member months as of the first quarter of 2014, and scaled to an annual units per 1,000 basis by multiplying by 12,000.
			DY1 to DY3	The annualized rate for each demonstration year was calculated by summing the utilization units for the year and dividing by the same year's total member months. The measure was then scaled to an annual units per 1,000 basis by multiplying by 12,000.

Measure	Measure Name	Definition	Evaluation Methodology	
78	All cause readmissions	The "All Cause Readmissions" measure reports the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of readmission. To be counted under this measure, acute inpatient discharges within 30 days of previous acute inpatient discharges are tracked during the measurement year.	Baseline to DY2	HSD furnished Deloitte with MMIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate 2014 rate.
79	Inpatient mental health/substance use services	The "Inpatient Mental Health/Substance Use" measure tracks the utilization for mental health and substance abuse services rendered in an inpatient setting.	Baseline to DY2	HSD furnished Deloitte with MMIS data where encounters and claims were summarized for psychiatric hospitals and residential treatment centers. The number of encounters are divided by the number of clients for the entire calendar year to arrive at the final rate in each demonstration year.
80	Asthma controller medication compliance (children)	"Asthma Controller Medication Compliance" is a HEDIS measure that reports the percentage of children with persistent asthma and who were dispensed appropriate medications that they remained on for the treatment period. Two rates of medication compliance are reported; those that remained on their medication for 50% of the treatment period, and those that	Baseline	HSD furnished Deloitte with audited HEDIS data for three of the four MCOs (PHP did not report on this measure in 2013). Deloitte combined the three plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the three MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		remained on their medication for 75% of the treatment period. To be counted under this measure, members must be identified as having persistent asthma in the measurement year or the year prior to the measurement year through claim encounter data and/or pharmacy data in either the current year or the prior year. The frequency of Centennial Care members earning and redeeming points for activities performed to manage their child's asthma is also tracked under this measure. According to the Centennial Rewards website, members may earn up to $75 (750 points) per calendar year for refilling their child's asthma as prescribed.	DY1 to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs in each year. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate. For the rewards component, HSD furnished Deloitte with Finity member rewards reports, which are summaries of the Centennial Rewards program that include the number of members registered in the program, number of members earning rewards, and number of members redeeming rewards in DY1 and DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
81	Diabetes - annual recommended tests (A1C, LDL, eye exam, nephropathy exam)	"Comprehensive Diabetes Care" is a HEDIS measure that reports the percentage of members ages 18 – 75 with Type 1 or Type 2 diabetes who had the applicable tests performed and whose health indicators aligned with the indicator category being tracked. To be counted under this measure, members must have been identified as having diabetes in the measurement year or the year prior to the measurement year via claim encounter data or pharmacy data. The frequency of Centennial Care members earning and redeeming points for activities to manage diabetes is also tracked under this measure. According to the Centennial Rewards website, members may earn up to $80 (800 points) for taking steps to manage their diabetes.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs in each year. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate. For the rewards component, HSD furnished Deloitte with Finity member rewards reports, which are summaries of the Centennial Rewards program that include the number of members registered in the program, number of members earning rewards, and number of members redeeming rewards in DY1 and DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
82	Prenatal program	The “Prenatal Program" measure was based on a collection of HEDIS measures on the frequency of ongoing prenatal care and postpartum care. The measures report on the percentage of deliveries that received various ranges of expected percentages of visits, the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery, and the percentage of deliveries that received a prenatal visit during the first trimester. To be counted under this measure, female members must be identified as having a live birth between November 6 of the prior year and November 5 of the measurement year. The frequency of Centennial Care members earning and redeeming points for activities to manage prenatal care is also tracked under this measure. According to the Centennial Rewards website, members who are pregnant may earn up to $100 (1,000 points) for joining the prenatal program sponsored by its health plan.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs in each year. Deloitte combined the four plans’ numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate. For the rewards component, HSD furnished Deloitte with Finity member rewards reports, which are summaries of the Centennial Rewards program that include the number of members registered in the program, number of members earning rewards, and number of members redeeming rewards in DY1 and DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
83	Treatment adherence - schizophrenia	"Treatment Adherence – Schizophrenia" is a HEDIS measure that reports the percentage of members diagnosed with schizophrenia that remain on their medication for at least 80% of the treatment period. To be counted under this measure, members ages 19 – 64 must be diagnosed with schizophrenia by having at least one acute inpatient claim with the diagnosis of schizophrenia or must have at least two outpatient, partial hospitalization, ED, or non-acute claims on different dates of service with the diagnosis of schizophrenia. The frequency of Centennial Care members earning and redeeming points for activities to manage their schizophrenia is also tracked under this measure. According to the Centennial Rewards website, members may earn up to $75 (750 points) for taking steps to manage their schizophrenia.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs in each year. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate. For the rewards component, HSD furnished Deloitte with Finity member rewards reports, which are summaries of the Centennial Rewards program that include the number of members registered in the program, number of members earning rewards, and number of members redeeming rewards in DY1 and DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
84	Treatment adherence - bipolar	The "Treatment Adherence – Bipolar" measure was intended to track treatment adherence for bipolar disorders. However, there are no known HEDIS measures related to the tracking of health status for bipolar individuals and MCOs were not required to track this activity. Therefore, this measure has been modified to track the frequency of Centennial Care members earning and redeeming points for activities to manage bipolar disorder. According to the Centennial Rewards website, members may earn up to $75 (750 points) per calendar year for taking steps to manage their bipolar condition. If, in the future, appropriate data and reporting become available, Deloitte will reassess this measures at that time.	DY1 to DY2	HSD furnished Deloitte with Finity member rewards reports, which are summaries of the Centennial Rewards program that include the number of members registered in the program, number of members earning rewards, and number of members redeeming rewards in DY1 and DY2.
85	Osteoporosis management in elderly women - females aged 65+ years	"Osteoporosis Management In Elderly Women – Females Age 65 and Over" is a measure that tracks the number of unique members and unique encounters related to osteoporosis over the course of the measurement year. The frequency of Centennial Care members earning and redeeming points for testing bone density, a test commonly performed to prescreen for osteoporosis, is also tracked under this measure. According to the Centennial Rewards website, members may earn up a one-time reward of $35 (350 points) by getting a bone density test.	Baseline to DY2	HSD provided an MMIS data extract for calendar years 2013 through 2015 to track the number of unique members and unique encounters related to osteoporosis in elderly women. This information was used to calculate an encounter rate by dividing encounters over clients. For the rewards component, HSD furnished Deloitte with Finity member rewards reports, which are summaries of the Centennial Rewards program that include the number of members registered in the program, number of members earning rewards, and number of members redeeming rewards in DY1 and DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
86	Annual dental visit - adult	The "Annual Dental Visits – Adults" measure tracks the percentage of adult members that had at least one dental visit during the measurement year. The annual dental visit HEDIS measure was used to track this rate and was reported specifically for the 19 – 21 age range. The frequency of Centennial Care adult members earning and redeeming points for having their annual dental visit is also tracked under this measure. According to the Centennial Rewards website, the Healthy Smiles program rewards members up to $25 (250 points) per calendar year.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs in each year. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate. For the rewards component, HSD furnished Deloitte with Finity member rewards reports, which are summaries of the Centennial Rewards program that include the number of members registered in the program, number of members earning rewards, and number of members redeeming rewards in DY1 and DY2.
87	Annual dental visit - child	The "Annual Dental Visits – Child" measure tracks the percentage of child members that had at least one dental visit during the measurement year. The annual dental visit HEDIS measure was used to track this rate and was reported specifically for the following age groups: 2-3 years, 4-6 years, 7-10 years, 11-14 years, and 15-18 years. The frequency of Centennial Care child members earning and redeeming points for having their annual dental visit is also tracked under this measure. According to the Centennial Rewards website, the Healthy Smiles program rewards members up to $25 (250 points) per calendar year.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs in each year. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate. For the rewards component, HSD furnished Deloitte with Finity member rewards reports, which are summaries of the Centennial Rewards program that include the number of members registered in the program, number of members earning rewards, and number of members redeeming rewards in DY1 and DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
88	Number of members spending credits	The "Number of Members Spending Credits" measure tracks the number of members redeeming and spending credits, or points, earned in the Centennial Rewards program relative to the number of people registered in the Centennial Rewards program. In previous measures described in this report, this information was also provided for specific points-earning activities that were applicable to the health condition under discussion. Here, this measure reports the total number of members earning or redeeming credits in the Centennial Rewards program, regardless of points-generating activity.	DY1 to DY2	HSD furnished Deloitte with Finity member rewards reports, which are summaries of the Centennial Rewards program that include the number of members registered in the program, number of members earning rewards, and number of members redeeming rewards in DY1 and DY2.
88	Percentage of expedited appeals resolved within three business days	HSD requires MCOs to establish and maintain an expedited review process for appeals and adhere to the allowed timeframe. Specifically: *"The contractor shall establish and maintain an expedited process for Appeals in accordance with 42 C.F.R. § 438.410. The contractor shall ensure that the expedited review process is convenient and efficient for the Member. The contractor shall resolve the expedited Appeal in accordance 42 C.F.R. § 438.408(b)(3) and (d)(2)…"*[144][145] The New Mexico Human Services Department (HSD) requires MCOs to track and	DY1 to DY2	The MCOs under the Salud and CoLTS programs did not report on this measure in 2013. Therefore, 2014 data will be utilized as the baseline. HSD furnished Deloitte with the Grievances and Appeals reports submitted by the four MCOs in each year. The reports covered 12 months of each year and contained counts of the total number of expedited appeals resolved, as well as the number and percent resolved within the three day standard. Deloitte combined the four plans' total resolved expedited appeals to establish a denominator for each year. Deloitte then combined the count of expedited appeals resolved within three days to establish a numerator for each year.

[144] Contractors may request an extension from HSD in accordance with 42CFR Section 438.408(c).
[145] Centennial Care Contract, Section 4.16.3 – Expedited Resolution of Appeals.

Measure	Measure Name	Definition	Evaluation Methodology	
		report on appeals and grievance activity on a monthly basis. This includes the number of new appeals filed and the number resolved timely or untimely that month. The acceptable time period for resolution is seventy-two hours after the receipt of the appeal. Timely resolution of expedited appeals is essential for ensuring members do not experience a delay in receiving urgently needed care (in situations where the initial denial is overturned). The measure examines the percentage of expedited appeals resolved within three days of receipt by the MCO.		
89	Percentage of grievances resolved within 30 days	HSD requires MCOs to adhere to timeliness standards for resolution of grievances, whether filed by members or providers. Grievances were defined in the Centennial Care managed care contract as follows: *"Grievance means an expression of dissatisfaction about any matter or aspect of the contractor or its operation, other than a contractor action."*[146]	DY1 to DY2	The MCOs under the Salud! and CoLTS programs did not report on this measure in 2013. Therefore, DY1 data will be utilized as the baseline. HSD furnished Deloitte with grievance resolution reports submitted by the four MCOs in each year. The reports covered 12 months of each year and contained counts of the total number of grievances resolved, as well as the number and percent resolved within the 30 day standard. Deloitte combined the four plans' total resolved grievances to establish a denominator for each year. Deloitte then combined the count of grievances resolved

[146] Centennial Care contract, Section 2 – Definitions, Acronyms and Abbreviations, page 13.

Measure	Measure Name	Definition	Evaluation Methodology	
		HSD also defines the allowable time period for resolution of grievances. Specifically: *"The contractor shall complete the investigation and final resolution process for grievances within 30 calendar days of the date the grievance is received by the contractor or as expeditiously as the member's health condition requires…"*[147][148] HSD requires MCOs to track and report grievance activity on a monthly basis. This includes the number of new grievances filed, the number carried over from the previous month, the number resolved timely or untimely that month, and the number still pending (for carry over to the next month's report). MCOs report member grievance activity as a distinct category. Failure to resolve member grievances timely could contribute to dissatisfaction with the program and have a negative impact on member access to care. The measure examines the percentage of grievances		within 30 days to establish a numerator for each year.

[147] Contractors may request an extension from HSD in accordance with 42 CFR § 438.408(c).
[148] Centennial Care Contract, Section 4.16.2 – Grievances, page 137.

Measure	Measure Name	Definition	Evaluation Methodology	
		resolved within 30 days of receipt by the MCO.		
90 91 92	Percentage of appeals upheld, partially overturned, and overturned	In conformance with federal regulations, HSD requires Centennial Care MCOs to adhere to the following procedures with respect to notices of action and appeals: *"The contractor shall mail a notice of action to the member or provider in accordance with the procedures and timeframes of 42 C.F.R. §438.404 and 431.200 unless such timeframe is prescribed in this section 4.16.2… The contractor may mail a notice of action no later than the date of the action for the following:* • *The contractor has factual information confirming the death of a member;* • *The contractor receives a signed written member statement requesting service termination or giving information requiring termination of covered services (where the member understands*	DY1 to DY2	The MCOs under the Salud! and CoLTS programs did not report on this measure in 2013. Therefore, 2014 data will be utilized as the baseline. HSD furnished Deloitte with Grievances and Appeal reports submitted by the four MCOs in each year. The reports covered 12 months of each year and contained counts of the total number of appeals resolved and the disposition of the appeals. Appeals that were listed as "pending" at the time the report was compiled were not included in the calculations of this measure.

Measure	Measure Name	Definition	Evaluation Methodology	
		that this must be the result of supplying that information); • *The member has been admitted to an institution where he or she is ineligible for further services;* • *The member's address is unknown and mail directed to him or her has no forwarding address;* • *The member has been accepted for Medicaid services in another state or US territory;* • *The member's physician prescribes a change in the level of medical care;* • *An adverse determination is made with regard to the preadmission screening requirements for nursing facility admissions; and* • *In accordance with 42 CFR Section 483.12(a)(5)(ii)*[149]. *A member may file an appeal of a contractor action either orally or in writing within (90) calendar days of receiving the contractor's notice of action. The representative or a provider acting on behalf of the member with the member's written consent, has the right to file an appeal of an action on behalf of the member."* [150] Appeals may be upheld (affirming the original determination), partially overturned, or overturned in full. HSD requires MCOs to track and report		

[149] Section relates to transfers and discharges from long term care facilities.
[150] Centennial Care Contract, Section 4.16.3 –Appeals, pages 147 – 148.

Measure	Measure Name	Definition	Evaluation Methodology	
		appeal activity, including the nature of the resolution. A high rate of overturned denials could indicate that MCOs' are applying too stringent a standard when making initial determinations. (Measures 90, 91, and 92 have been combined to eliminate redundancy in reporting results.) The measure examines the percentage of appeals that were upheld, partially overturned, and overturned in full upon review.		
93	Number and percentage of calls answered within 30 seconds	"Call answer timeliness" is a HEDIS measure that reports the frequency with which calls are answered within the NCQA standard of 30 seconds. HSD requires that the participating MCOs operate a toll-free Member Services Call Center. HSD also defines performance standards for the call centers: *"The contractor shall adequately staff the Member services information line to ensure that the line, including the nurse triage/nurse advice line or queue, meets the following performance standards: less than five percent (5%) call abandonment rate; eighty-five percent (85%) of calls are answered by a live voice within 30 seconds (or the prevailing benchmark established by NCQA); and average wait time for assistance does not exceed two (2) minutes."*	Baseline to DY1	HSD furnished Deloitte with audited HEDIS data for the four MCOs in each year. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
			DY2	HSD furnished Deloitte with audited HEDIS data for two of the four MCOs (MHC and BCBS did not report on this measure in 2015). Deloitte combined the two plans' numerator and denominator values to calculate an aggregate rate. Although to our knowledge the two MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		The call centers are an important resource for members in understanding program benefits and accessing services. If members have difficulty getting through to the call center, their overall satisfaction with the plan is likely to be affected. HSD requires contracting MCOs to report call center performance as a component of their annual HEDIS submissions.		
94	Number and percentage participants satisfied with care coordination	Many Centennial Care members have complex health care needs for which they receive care from multiple physicians. "How often personal doctor informed about care from other doctors" is a CAHPS measure that rates member satisfaction with how well his or her personal doctor is kept informed by other doctors. Although care coordination encompasses more than communication between physicians, it is an important component of the process and one that is visible to the member. If a member finds his or her personal doctor is not well-informed about the member's interaction with specialists, it is likely to negatively affect the member's satisfaction with his or her doctor and plan. The CAHPS survey asks members to rate how often their personal doctor is informed about care from other doctors using a scale of one to four, where one	Baseline	HSD furnished Deloitte with audited CY 2013 CAHPS data for the four MCOs. One plan submitted data only for the adult population. The other three plans submitted data for all three populations (adults, children – general, and – CCC). Each plan provided a rate that documented the percentage of respondents answering "usually" or "always." Deloitte calculated an unweighted average of the plans' survey results. Deloitte used the 2016 SPH Analytics Benchmark rate for the adult and general child populations. For the children with chronic conditions population Deloitte used the 2015 Quality Compass All Plans benchmark rate, as the 2016 SPH Analytics Benchmark rate could not be identified for this population.
			DY1 to DY2	For the DY1 and DY2, HSD furnished Deloitte with audited CAHPS data for the four MCOs. Deloitte received data for all three populations from all MCOs. Deloitte calculated an unweighted averages of the plans' survey results.

Measure	Measure Name	Definition	Evaluation Methodology	
		is “never,” two is “sometimes,” three is “usually” and four is “always.” There are separate CAHPS surveys for adults and children. The data for children is further segmented into the general population and children with chronic conditions (CCC). (Parents/guardians complete the latter surveys on behalf of their enrolled children.) These surveys are voluntary, and thus the data they collect are vulnerable to non-response bias and selection bias. These results should be reviewed keeping in mind that they will not reflect the responses of those members who elected not to fill out a survey. A more complete response from all members could have resulted in numbers either higher or lower than reported here. The response rate from the selected sample usually hovers between 20% and 30%, leaving open the possibility that more consistent responses could produce materially different results.		

Measure	Measure Name	Definition	Evaluation Methodology	
95	Rating of personal doctor	"Rating of Personal Doctor" is a CAHPS measure that evaluates member satisfaction with their PCP. The PCP is a central figure in the member's care; the member's rating of his or her doctor can be expected to influence the member's overall perception of plan quality. The CAHPS survey asks members to rate their personal doctor on a scale of zero to ten, where zero is the worst and ten is the best. A score of eight, nine, or ten is typically considered to indicate member satisfaction. There are separate CAHPS surveys for adults and children. The data for children is further segmented into the general population and CCC. (Parents/guardians complete the latter surveys on behalf of their enrolled children.) These surveys are voluntary, and thus the data they collect are vulnerable to non-response bias and selection bias. These results should be reviewed keeping in mind that they will not reflect the responses of those members who elected not to fill out a survey. A more complete response from all members could have resulted in numbers either higher or lower than reported here. The response rate from the selected sample usually hovers between 20% and 30% percent, leaving open the possibility that more consistent responses would produce materially different results.	Baseline	HSD furnished Deloitte with audited CY 2013 CAHPS data for the four MCOs. One plan submitted data only for the adult population. The other three plans submitted data for all three populations (adults, children – general, and – CCC). Each plan provided a rate that documented the percentage of respondents answering eight, nine, or ten. Deloitte calculated an unweighted average of the plans' survey results.
			DY1 to DY2	For the DY1 and DY2, HSD furnished Deloitte with audited CAHPS data for the four MCOs. Deloitte received data for all three populations from all MCOs. Deloitte calculated an unweighted averages of the plans' survey results.

Measure	Measure Name	Definition	Evaluation Methodology	
96	Rating of health care	"Rating of Health Care" is a CAHPS measure that evaluates overall member satisfaction with their care. The CAHPS survey asks members to rate their health care on a scale of zero to ten, where zero is the worst and ten is the best. A score of eight, nine, or ten is typically considered to indicate member satisfaction. There are separate CAHPS surveys for adults and children. The data for children is further segmented into the general population and (CCC). (Parents/guardians complete the latter surveys on behalf of their enrolled children.) These surveys are voluntary, and thus the data they collect are vulnerable to non-response bias and selection bias. These results should be reviewed keeping in mind that they will not reflect the responses of those members who elected not to fill out a survey. A more complete response from all members could have resulted in numbers either higher or lower than reported here. The response rate from the selected sample usually hovers between 20% and 30% percent, leaving open the possibility that more consistent responses would produce materially different results.	Baseline	HSD furnished Deloitte with audited CY 2013 CAHPS data for the four MCOs. One plan submitted data only for the adult population. The other three plans submitted data for all three populations (adults, children – general, and – CCC). Each plan provided a rate that documented the percentage of respondents answering eight, nine or ten. Deloitte calculated an unweighted average of the plans' survey results.
			DY1 to DY2	For the DY1 and DY2, HSD furnished Deloitte with audited CAHPS data for the four MCOs. Deloitte received data for all three populations from all MCOs. Deloitte calculated an unweighted averages of the plans' survey results.

Measure	Measure Name	Definition	Evaluation Methodology	
97	How well doctors communicate	"How Well Doctors Communicate" is a CAHPS composite measure that combines data from responses to four survey items: • Doctors explained things in a way that was easy to understand • Doctors listened carefully • Doctors showed respect for what you had to say • Doctors spent enough time with you. The CAHPS survey asks members to rate their doctors on each item using a scale of one to four, where one is "never," two is "sometimes," three is "usually," and four is "always." In the CAHPS report the answers to these questions are combined and used to	Baseline	HSD furnished Deloitte with audited CAHPS data for the four MCOs. One plan submitted data only for the adult population. The other three plans submitted data for all three populations (adults, children – general, and – CCC). Each plan provided a rate that documented the composite percentage of respondents answering "usually" or "always." Deloitte calculated an unweighted average of the plans' survey results.

Measure	Measure Name	Definition	Evaluation Methodology	
		calculate an overall satisfaction rate with doctor communication. There are separate CAHPS surveys for adults and children. The data for children is further segmented into the general population and CCC. (Parents/guardians complete the latter surveys on behalf of their enrolled children.) These surveys are voluntary, and thus the data they collect are vulnerable to non-response bias and selection bias. These results should be reviewed keeping in mind that they will not reflect the responses of those members who elected not to fill out a survey. A more complete response from all members could have resulted in numbers either higher or lower than reported here. The response rate from the selected sample usually hovers between 20% and 30% percent, leaving open the possibility that more consistent responses would produce materially different results.	DY1 to DY2	For the DY1 and DY2, HSD furnished Deloitte with audited CAHPS data for the four MCOs. Deloitte received data for all three populations from all MCOs. Deloitte calculated an unweighted averages of the plans' survey results.

Measure	Measure Name	Definition	Evaluation Methodology	
98	Customer service satisfaction	"Customer Service Satisfaction" is a CAHPS composite measure that combines data from responses to four survey items: • Found needed information in written materials and on the internet • Health plan forms were easy to fill out • Received needed information from the health plan's customer service • Customer service staff treated you with courtesy and respect. The CAHPS survey asks members to rate their customer service experience on each item using a scale of one to four, where one is "never," two is "sometimes," three is "usually," and four is "always." In the CAHPS report the answers to these questions are combined and used to calculate an	Baseline	HSD furnished Deloitte with audited CAHPS data for the four MCOs. One plan submitted data only for the adult population. The other three plans submitted data for all three populations (adults, children – general, and – CCC). Each plan provided a rate that documented the composite percentage of respondents answering "usually" or "always." Deloitte calculated an unweighted average of the plans' survey results.

Measure	Measure Name	Definition	Evaluation Methodology	
		overall satisfaction rate with doctor communication. There are separate CAHPS surveys for adults and children. The data for children is further segmented into the general population and CCC. (Parents/guardians complete the latter surveys on behalf of their enrolled children.) These surveys are voluntary, and thus the data they collect are vulnerable to non-response bias and selection bias. These results should be reviewed keeping in mind that they will not reflect the responses of those members who elected not to fill out a survey. A more complete response from all members could have resulted in numbers either higher or lower than reported here. The response rate from the selected sample usually hovers between 20% and 30%, leaving open the possibility that more consistent responses would produce materially different results.	DY1 to DY2	For the DY1 and DY2, HSD furnished Deloitte with audited CAHPS data for the four MCOs. Deloitte received data for all three populations from all MCOs. Deloitte calculated an unweighted averages of the plans' survey results.

Measure	Measure Name	Definition	Evaluation Methodology	
99	Rating of specialist seen most often	"Rating of Specialist Seen Most Often" evaluates member satisfaction with the provider most critical to the member's care, in addition to the member's PCP. The CAHPS survey asks members to rate their specialist on a scale of zero to ten, where zero is the worst and ten is the best. A score of eight, nine, or ten is typically considered to indicate member satisfaction. There are separate CAHPS surveys for adults and children. The data for children is further segmented into the general population and CCC. (Parents/guardians complete the latter surveys on behalf of their enrolled children.) These surveys are voluntary, and thus the data they collect are vulnerable to non-response bias and selection bias. These results should be reviewed keeping in mind that they will not reflect the responses of those members who elected not to fill out a survey. A more complete response from all members could have resulted in numbers either higher or lower than reported here. The response rate from the selected sample usually hovers between 20% and 30%, leaving open the possibility that more consistent responses would produce materially different results.	Baseline	HSD furnished Deloitte with audited CAHPS data for the four MCOs. One plan submitted data only for the adult population. The other three plans submitted data for all three populations (adults, children – general, and – CCC). Each plan provided a rate that documented the composite percentage of respondents answering "usually" or "always." Deloitte calculated an unweighted average of the plans' survey results.
			DY1 to DY2	For the DY1 and DY2, HSD furnished Deloitte with audited CAHPS data for the four MCOs. Deloitte received data for all three populations from all MCOs. Deloitte calculated an unweighted averages of the plans' survey results.

Measure	Measure Name	Definition	Evaluation Methodology	
100	Percentage of clean claims adjudicated in 30/90 days	HSD requires MCOs to adhere to timeliness standards for adjudication of clean claims. The standards also apply to any capitated subcontractors responsible for processing provider claims. Clean claims are defined in the Centennial Care contract as follows: "Clean claim means a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in HSD's system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity." HSD defined two sets of timeliness standards, the first of which applies to Indian Health Service/Tribal/Urban Indian (I/T/U) and long term care providers, and the second of which applies to all other providers. Specifically: "For claims from I/T/Us, day activity providers, assisted living providers, nursing facilities and home care agencies, including community benefit providers, ninety-five percent (95%) of clean claims must be adjudicated within a time period of no greater than fifteen (15) calendar days of receipt and ninety-nine percent (99%) or more of clean claims must be adjudicated within	SFY 2013	For the baseline calculation, HSD furnished Deloitte with monthly standardized claims timeliness reports submitted by the four MCOs contracted under the Salud! program, the two MCOs contracted under the CoLTS program and the Behavioral Health Organization (BHO) contracted to provider behavioral health benefits to both Salud! and CoLTS members. The reports covered the 12 months of SFY 2013 and contained counts of the total number of clean claims processed, as well as the number and percent adjudicated within 30 and 90 calendar days. Deloitte combined the seven plans' total clean claim counts for SFY 2013 to establish a denominator. Deloitte then combined the 30 and 90 day adjudication counts to establish numerators for calculation of 30 and 90 day rates.
			DY1	For the DY1 rate, HSD furnished Deloitte with standardized claims timeliness reports submitted by the four MCOs. The reports covered the 12 months of calendar year 2014 and contained counts of the total number of clean claims processed, as well as the number and percent adjudicated within program timeliness standards. The MCOs provided separate data for providers falling under the 15/30 day standard and providers falling under the 30/90 day standard. Deloitte combined the four plans' total clean claim counts for CY 2014 to establish a denominator. Deloitte then combined the 30 and 90 day adjudication counts to establish numerators for calculation of 30 and 90 day rates. Deloitte was able to compare SFY 2013 and DY1 performance with respect to the 30/90 day standard, which was captured in both sets of

Measure	Measure Name	Definition	Evaluation Methodology	
		a time period of no greater than thirty (30) calendar days of receipt; *"For all other claims, ninety percent (90%) of all clean claims must be adjudicated within thirty (30) calendar days of receipt, and ninety-nine percent (99%) of all clean claims must be adjudicated within ninety (90) calendar days of receipt."* [151] The measure examines claims that have been adjudicated (i.e., paid in full), paid in part and denied in part, or denied in full.		reports. Data for the 15/30 day standard was reported only in 2014 and will serve as a baseline for longitudinal analysis.
			DY2	For DY2 HSD supplied Deloitte with rates from each MCO for several types of rendering providers (BH providers, PH providers, BH and PH providers, I/T/Us, specialty-pay providers, and an aggregate rate of all providers). These rates did not come with numerators and denominators, so for DY2 the rates could not be weighted in their aggregate. Deloitte produced the DY2 30/90 day standard rate by calculating the straight average for the three categories of providers whose claims are adjudicated under the 30/90 day standard. For the DY2 15/30 day standard rate, Deloitte calculated the straight average of the two types of claims that adjudicated under that standard. The variations in calculation methodologies should be noted year-to-year when comparing results.

[151] Centennial Care contract, Section 4.19 – Claims Management, page 168.

Measure	Measure Name	Definition	Evaluation Methodology	
101	Percentage of claims denied	HSD requires MCOs to track and report the percentage of clean claims denied for payment. A high denial rate can be an indication of confusion among providers regarding coverage guidelines, prior authorization requirements and/or proper billing procedures. Clean claims are defined in the Centennial Care contract as follows: *"Clean claim means a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in HSD's system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity."*[152] The measure examines clean claims that have been adjudicated and denied.	SFY 2013	For the Baseline calculation, HSD furnished Deloitte with monthly standardized claims timeliness reports submitted by the four MCOs contracted under the Salud! program, the two MCOs contracted under the CoLTS program and the BHO contracted to provider behavioral health benefits to both Salud! and CoLTS members. The reports covered the 12 months of SFY 2013 and contained counts of the total number of clean claims processed, as well as the number and percent denied upon adjudication. Deloitte combined the seven plans' total clean claim counts for SFY 2013 to establish a denominator. Deloitte then combined the denial counts to establish a numerator.
			DY1	For the DY1 rate, HSD furnished Deloitte with standardized claims timeliness reports submitted by the four MCOs. The reports covered the 12 months of calendar year 2014 and contained counts of the total number of clean claims processed, as well as the number and percent denied upon adjudication. Deloitte combined the four plans' total clean claim counts for CY2014 to establish a denominator. Deloitte then combined the denial counts to establish a numerator.

[152] Centennial Care contract, Section 2 – Definitions, Acronyms and Abbreviations, page 9.

Measure	Measure Name	Definition	Evaluation Methodology	
			DY2	For DY2 HSD supplied Deloitte with rates from each MCO for several types of rendering providers (BH providers, PH providers, BH and PH providers, I/T/Us, specialty-pay providers, and an aggregate rate of all providers). These rates did not come with numerators and denominators, so for DY2, Deloitte calculated the straight average of each MCO's aggregate claim denial rate. The variations in calculation methodologies should be noted year-to-year when comparing results.
102	Dollar accuracy rate	HSD requires MCOs to track and report the dollar accuracy of paid claims, based on a quarterly MCO audit of a random sample of claims. A high inaccurate percentage can be an indication of claims management issues, including but not limited to: incorrect pricing of claims, payment of duplicate claims, and/or payment for non-covered charges. HSD requires separate auditing and reporting of results for ten claim types: • Inpatient hospital	DY1	The MCOs under the Salud! and CoLTS programs did not report on this measure in 2013. Therefore, DY1 data will be utilized as the baseline. For the baseline calculation, HSD furnished Deloitte with quarterly audit reports submitted by the four MCOs. The reports covered the 12 months of CY2014[153]. Deloitte combined the four plans' total paid amounts, by claim type, to establish claim type-specific denominators. Deloitte then combined the dollar error amounts, by claim type, and subtracted these amounts from the totals to establish claim type-specific numerators. Deloitte performed the same exercise across all claim types to establish an aggregate denominator and numerator.

[153] Deloitte received all four quarterly reports for three of the four Centennial Care MCOs and three of the quarterly reports for the fourth MCO. Deloitte does not believe that the absence of one quarterly report is of material importance in calculating a percentage accuracy rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		• Outpatient hospital • Professional • Behavioral health • Nursing Facility • I/T/U • Medicare crossover • Home- and Community-Based Services (HCBS) • Dental • Federally Qualified Health Center/Rural Health Clinic (FQHC/RHC) MCOs select at least one hundred paid claims, by claim type, on a quarterly basis. The claims are audited both for dollar accuracy and procedural accuracy. Dollar errors are classified either as overpayments or underpayments. MCOs report the total dollars paid and the total amount of overpayments and underpayments. The overpayment and underpayment amounts are combined to establish a total inaccurate dollar amount by claim type and for all audited claims in aggregate. The measure examines percentage of total dollars paid correctly (no overpayment or underpayment) out of the total paid dollars for audited claims.	DY2	For DY2 HSD supplied Deloitte with dollar accuracy rates from each MCO by claim type. These rates did not include underlying dollar amounts, so the DY2 aggregate rate was calculated as a straight average of MCO rates instead of a weighted average. No aggregate accuracy rate for all types of claims was available. The variations in calculation methodologies should be noted year-to-year when comparing results.

Measure	Measure Name	Definition	Evaluation Methodology	
103	Percentage of grievances resolved on time	HSD requires MCOs to adhere to timeliness standards for resolution of grievances, whether filed by members or providers. Grievances are defined in the Centennial Care contract as follows: *"Grievance means an expression of dissatisfaction about any matter or aspect of the contractor or its operation, other than a contractor action."* [154][155] HSD also defines the allowable time period for resolution of grievances. Specifically: *"The contractor shall complete the investigation and final resolution process for grievances within thirty (30) calendar days of the date the grievance is received by the contractor or as expeditiously as the member's health condition requires…"*[156][157] HSD requires MCOs to track and report grievance activity on a monthly basis. This includes the number of new grievances filed, the number carried over from the previous month, the number resolved timely or untimely that month, and the number still pending (for carry over to the next month's report).	DY1 to DY2	The MCOs under the Salud! and CoLTS programs did not report on this measure in 2013. Therefore, calendar year 2014 Centennial Care data was utilized as the baseline. HSD furnished Deloitte with grievance resolution reports submitted by the four MCOs in each year. The reports covered 12 months of each year and contained counts of the total number of grievances resolved, as well as the number and percent resolved within the 30 day standard. Deloitte combined the four plans' total resolved grievances to establish respective denominators for each year. Deloitte then combined the count of grievances resolved within 30 days to establish a numerator for each year.

[154] Centennial Care contract, Section 2 – Definitions, Acronyms and Abbreviations, page 13.
[155] Actions refer to service reductions or denials and are addressed through the appeals, rather than grievance, process.
[156] Centennial Care contract, Section 4.16 – Grievances and Appeals, page 146.
[157] Contractors may request an extension from HSD in accordance with 42CFR Section 438.408(c).

Measure	Measure Name	Definition	Evaluation Methodology	
		MCOs report provider grievance activity as a distinct category. Failure to resolve provider grievances timely could contribute to dissatisfaction with the program and have a negative impact on provider participation and member access to care. The measure examines the percentage of grievances resolved within 30 days of receipt by the MCO.		
104	Percentage of provider appeals resolved on time	In conformance with federal regulations, HSD requires Centennial Care MCOs (contractors) to adhere to the following procedures with respect to notices of action and appeals: *"The contractor shall mail a notice of action no later than the date of the action for the following:* • *The contractor has factual information confirming the death of a member;* • *The contractor receives a signed written member statement requesting service termination or giving information requiring termination of covered services (where the member understands that this must be the result of supplying that information);* • *The member has been admitted to an institution where he or she is ineligible for further services;*	DY1 to DY2	The MCOs under the Salud! and CoLTS programs did not report on this measure in 2013. Therefore, calendar year 2014 Centennial Care data was utilized as the baseline. HSD furnished Deloitte with grievance resolution reports submitted by the four MCOs in each year. The reports covered the 12 months of each year and contained counts of the total number of appeals resolved, as well as the number and percent resolved within the 30 day standard. Deloitte combined the four plans' total resolved grievances to establish respective denominators for each year. Deloitte then combined the count of grievances resolved within 30 days to establish a numerator for each year.

Measure	Measure Name	Definition	Evaluation Methodology	
		• *The member's address is unknown and mail directed to him or her has no forwarding address;* • *The member has been accepted for Medicaid services in another state or US territory;* • *The member's physician prescribes a change in the level of medical care;* • *An adverse determination is made with regard to the preadmission screening requirements for nursing facility admissions; and* • *In accordance with 42 CFR Section 483.12(a)(5)(ii)*[158]*.* *A member may file an appeal of a contractor action either orally or in writing within (90) calendar days of receiving the contractor's notice of action. The representative or a provider acting on behalf of the member with the member's written consent, has the right to file an appeal of an action on behalf of the member."*[159] HSD requires MCOs to adhere to timeliness standards for resolution of standard and expedited appeals. Specifically: *Standard appeals - "The contractor has thirty (30) calendar days from the date the initial oral or written appeal is*		

[158] Section relates to transfers and discharges from long term care facilities.
[159] Centennial Care contract, Section 4.16 – Grievances and Appeals, pp 147-148 (emphasis added).

Measure	Measure Name	Definition	Evaluation Methodology	
		received by the contractor to resolve the appeal."[160] *Expedited appeals – "The contractor shall resolve the expedited appeal in accordance with 42 CFR Section 438.408(b)(3) and (d)(2)."*[161] The CFR section cited in the Centennial Care contract includes the following language: *"For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than three working days after the MCO or PIHP receives the appeal. This timeframe may be extended under paragraph (c) of this section."* Paragraph (c) permits the MCO to extend the timeframe by up to fourteen calendar days if the enrollee requests the extension or the MCO shows (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest. HSD requires MCOs to track and report appeal activity, including the date the appeal was filed and the date of resolution. MCOs report appeals filed by providers on behalf of members as a distinct category. Failure to resolve		

[160] Centennial Care contract, Section 4.16 – Grievances and Appeals, page 148.
[161] Centennial Care contract, Section 4.16 – Grievances and Appeals, page 149.

Measure	Measure Name	Definition	Evaluation Methodology	
		these appeals timely could contribute to dissatisfaction with the program and have a negative impact on provider participation and member access to care. The measure examines the percentage of standard appeals resolved timely by the MCO.		
106	Number of eligible providers receiving EHR incentive payments	The Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of the American Recovery and Reinvestment Act of 2009, committed the federal government to supporting the development, adoption and meaningful use of EHRs. The EHR offers the potential to improve care coordination and achieve cost savings through consolidation and real time sharing of clinical data across providers and care settings, while also facilitating a patient's access to his or her personal health data. The federal Centers for Medicare and Medicaid Services (CMS) has undertaken a multi-stage EHR incentive payment methodology to encourage adoption and meaningful use of EHRs by Medicare providers. Each state Medicaid program, including New Mexico's, has established a corresponding incentive	2011 to 2016	HSD generated a report with counts of the number of eligible hospitals and professional providers that qualified for an initial incentive payment in 2013 or for a meaningful use incentive payment. Deloitte added the initial payment count to the cumulative count for 2011 – 2012, to arrive at a baseline number for this portion of the measure. (Meaningful use counts are unique to each year and not cumulative.) Deloitte replied on the same reports generated by HSD in DY1 through DY3.

Measure	Measure Name	Definition	Evaluation Methodology	
		methodology for Medicaid providers in accordance with federal regulations. HSD included a definition of EHRs in the Centennial Care MCO contract. Specifically: *"Electronic Health Record (EHR) means a record in digital format that is a systematic collection of electronic health information. Electronic health records may contain a range of data, including demographics, medical history, medication and allergies, immunization status, laboratory test results, radiology images, vital signs, personal statistics such as age and weight, and billing information."*[162] HSD also required MCOs to partner with the Department in facilitating adoption of EHRs by New Mexico providers. Specifically: *"The contractor shall participate in, and, as may be directed, implement any Health Information Exchange or Electronic Health Record initiatives undertaken by HSD or other entities."*[163] Under the federally-established rules for EHR incentive payments, Medicaid providers can receive up to six incentive payments. The payments are made on an annual basis and can be earned over non-consecutive years. The eligible		

[162] Centennial Care contract, Section 2 – Definitions, Acronyms and Abbreviations, pp 11-12.
[163] Centennial Care contract, Section 4.20 – Information Systems, page 176.

Measure	Measure Name	Definition	Evaluation Methodology	
		provider types include hospitals and professionals (physicians, dentists, nurse practitioners, certified nurse midwives and physician assistants). Providers qualify for an initial payment upon attesting that they have adopted, implemented or upgraded federally-certified EHR technology. (The federal government has raised the standards for the minimally allowable technology over time). Providers qualify for up to five additional annual payments by attesting that they have met the meaningful use standard in effect for that year. Incentive payment rules differ by provider type. For example, hospitals can receive both Medicare and Medicaid incentive payments in the same year but professionals cannot. Hospitals must meet a 10% Medicaid patient volume threshold; the corresponding threshold for professionals is 30%. There are additional restrictions for individual provider types. For example, physician assistants can qualify for an incentive payment only if they practice at an FQHC. HSD has tracked the number of eligible and participating providers, by provider type, since the program opened to Medicaid providers in 2011. In 2011, 628 eligible professionals and 25 eligible hospitals attested to adopting, implementing or upgrading a certified		

Measure	Measure Name	Definition	Evaluation Methodology	
		EHR and qualified for an initial incentive payment. In 2012, an additional 5 hospitals and 690 professionals made this attestation. At the same time, 5 of the original attesting hospitals from 2011, and 245 of the original attesting professionals met the meaningful use standard and qualified for a second incentive payment. The measure examines the cumulative number and percentage of eligible providers (hospitals and professionals) who have qualified for an initial incentive payment through adoption, implementation or upgrading of certified EHR technology. The measure also examines the number and percentage who have qualified for a meaningful use incentive payment in a calendar year.		
108	Percentage of claims paid accurately	HSD requires MCOs to track and report the percentage of provider claims paid accurately, based on a quarterly MCO audit of a random sample of claims. A high inaccurate percentage can be an indication of claims management issues, including but not limited to: incorrect pricing of claims, payment of duplicate claims and/or payment for non-covered charges. HSD requires separate auditing and reporting of results for ten claim types: • Inpatient hospital	DY1	The MCOs under the Salud! and CoLTS programs did not report on this measure in 2013. Therefore, DY1 data will be utilized as the baseline. For the baseline calculation, HSD furnished Deloitte with quarterly audit reports submitted by the four MCOs. The reports covered the 12 months of CY 2014. Deloitte combined the four plans' total paid claim counts, by claim type, to establish claim type-specific denominators. Deloitte then combined the claims without errors, by claim type, to establish claim type-specific numerators. Deloitte performed the same exercise across all claim types to establish an aggregate denominator and numerator.

Measure	Measure Name	Definition	Evaluation Methodology	
		• Outpatient hospital • Professional • Behavioral health • Nursing Facility • Indian Health Service/Tribal/Urban Indian (I/T/U) • Medicare crossover • Home- and Community-Based Services (HCBS) • Dental • Federally Qualified Health Center/Rural Health Clinic (FQHC/RHC) MCOs select at least one hundred paid claims, by claim type, on a quarterly basis. The claims are audited both for dollar accuracy and procedural accuracy. Dollar errors are classified either as overpayments or underpayments. MCOs report the total dollars paid and the total amount of overpayments and underpayments. The overpayment and underpayment amounts are combined to establish a total inaccurate dollar amount by claim type and for all audited claims in aggregate[164]. The measure examines percentage of provider claims paid correctly (no overpayment or underpayment) out of the total audited claims.	DY2	For DY2 HSD supplied Deloitte with claim accuracy rates from each MCO by claim type. These rates did not include underlying claim counts, so the DY2 aggregate rate was calculated as a straight average of MCO rates instead of a weighted average. No aggregate accuracy rate for all types of claims was available. The variations in calculation methodologies should be noted year-to-year when comparing results.

[164] Both values are treated as positive numbers. For example, an underpayment of $100 on a first claim and an overpayment of $50 on a second claim should be combined and reported as a $150 total error amount.

Measure	Measure Name	Definition	Evaluation Methodology	
109	PCMH Membership and Hospital/ER Utilization (Use and Outcomes of Payment Reforms)	The PCMH Membership and Hospital/ER Utilization measure provides key metrics pertaining to members attributed to a PCMH as well as the impact on key member outcome metrics. This information serves as a proxy for payment reform initiatives as the PCMH model undergoes various levels of credentialing by the NCQA.	DY1 to DY2	HSD provided Deloitte with MCO reports containing membership attributed to a PCMH as well as key ER and hospital admission utilization metrics. The calendar year totals were summed across MCOs and the ER and hospital admission metrics were compared to PCMH membership in each respective year.

B. Data Sources

The following table identifies the data sources used to support measure development and analysis. The table is structured by measure, but some measures were supported by information found in the same data source. Measures with gray shading were retired due to insufficient data.

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
1	Access to preventive/ambulatory health services among Centennial Care enrollees in aggregate and within subgroups	MCO HEDIS reports	2013	N/A
2	Mental health services utilization	MCO HEDIS reports	2014	N/A
3	Number of telemedicine providers and telemedicine utilization	Ad hoc MCO report	2013	N/A
4	Number and percentage of people meeting nursing facility level of care (NF LOC) who are in a nursing facility	Ad hoc data provided via email from HSD	2013	N/A
5	Number and percentage who are receiving home- and community-based services (HCBS)	Ad hoc data provided via email from HSD	2013	N/A
6	Number and percentage of people with annual dental visit	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
7	Enrollment in Centennial Care as a percentage of state population	Mercer Data Dashboard and US Census Bureau residency estimates	2014	N/A
8	Number of Native Americans opting-in and opting-out of Centennial Care	Native American Opt In reports	2014	N/A
10	Number and percentage of participants with BH conditions who accessed any of the three new BH services (respite, family support, and recovery)	BH Clients with Respite, Familty Support, Recovery Services MMIS reports	2014	N/A
11	Number and percentage of unduplicated participants with at least one PCP visit	PCP Visits MMIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
12	Number/ratio of enrollees to participating providers	MCO reports (HSD 3)	2014	N/A
13	Percentage of primary care provider with open panels	MCO reports (HSD 3)	2014	N/A
14	Number and percentage of substance use disorder participants with follow-up 7 and 30 days after leaving Residential Treatment Center (RTC)	MCO reports (HSD 5)	2014	N/A

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
15	Number and percentage of Behavioral Health (BH) participants with follow-up after hospitalization of mental illness	MCO HEDIS reports	2014	The NQCA State of Health Quality 2016 Report (for CY 2015)
16	Childhood Immunization Status	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
17	Immunization for Adolescents	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
18	Well-Child Visits in First Months of Life	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
19	Well-Child Visits in Third, Fourth, Fifth and Sixth Years of Life	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
20	Adolescent Well Care Visits	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
21	Prenatal and Postpartum Care	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
22	Frequency of Ongoing Prenatal Care	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
23	Breast Cancer Screening for Women	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
24	Cervical Cancer Screening for Women	MCO HEDIS reports	2013	N/A
25	Flu Vaccinations for Adults	Flu Vaccination MMIS reports	2013	N/A
26	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment	MCO HEDIS reports	2014	The NQCA State of Health Quality 2016

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
				Report (for CY 2015)
27	Geographic Access Measures	MCO reports (HSD 55)	2014	N/A
28	Number and percentage of participants with health risk assessments (HRA) completed within contract timeframes	MCO reports (HSD 6)	2014	N/A
29	Number and percentage of participants who received a care coordination designation and assignment of care coordinator within contract timeframes	MCO reports (HSD 6)	2014	N/A
30	Number and percentage of participants in care coordination Level 2 that had comprehensive needs assessments scheduled and completed within contract timeframes	MCO reports (HSD 6)	2014	N/A
31	Number and percentage of participants in care coordination Level 3 that had comprehensive needs assessments scheduled and completed within contract timeframes	MCO reports (HSD 6)	2014	N/A
32	Number and percentage of participants in care coordination Level 2 who received in-person visits and telephone contact within contract timeframes	MCO reports (HSD 6)	2014	N/A
33	Number and percentage of participants in care coordination Level 3 who received in-person visits and telephone contact within contract timeframes	MCO reports (HSD 6)	2014	N/A
34	Number and percentage of participants the MCO is unable to locate for care coordination	MCO reports (HSD 6)	2014	N/A
35	Number and percentage of participants in Nursing Facility (NF) transitioning to community (HCBS)	MCO reports (HSD 7)	2014	N/A
36	Number and percentage of participants who refuse care coordination	MCO reports (HSD 6)	2014	N/A
37	EPSDT screening ratio	Centers for Medicare & Medicaid (CMS) 416 Report	2013	Federal Fiscal Year (FFY) 2015 National CMS-416 Annual EPSDT Participation Report

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
38	Annual monitoring for patients on persistent medications	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
39	Medication management for people with asthma	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
40	Asthma medication ratio	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
41	Adult BMI assessment and weight assessment for children/adolescents	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
42	Comprehensive diabetes care	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
43	Ambulatory Care Sensitive (ACS) admission rates: diabetes short and long term complications, uncontrolled admission rates	Centennial Care Diabetes inpatient encounters (PQI) report and MMIS report	2013 (LT diabetes) 2014 (ST diabetes)	N/A
44	ACS admission rates for COPD or asthma in older adults; asthma in younger adults	ACS MMIS reports	2013	N/A
45	ACS admission rates for hypertension	ACS MMIS reports	2013	N/A
46	ACS admission rates for pediatric asthma	ACS MMIS reports	2013	N/A
47	Number and percentage of potentially avoidable ER visits	MCO reports (HSD 40)	2014	N/A
48	Medical assistance with smoking and tobacco use cessation	MCO CAHPS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
49	Number of critical incidents by reporting category	MCO Quarterly Reports (critical incident report)	2014	N/A
50	Antidepressant medication management	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
51	Inpatient admissions to psychiatric hospitals and RTCs	Admissions for Inpatient Psychiatric Hospitals (Claims type A and I) and RTCs MMIS reports	2013	N/A
52	Percentage of nursing facility residents who transitioned from a low nursing facility to a high nursing facility	MCO reports (HSD 8)	2014	N/A
53	Fall risk intervention	HEDIS rates calculated by Mercer	2014 (updated to reflect new data reporting)	N/A
54	Percentage of the population accessing both a behavioral health service and a PCP visit in the same year	BH-PCP Visits MMIS reports	2013	N/A
55	Percentage of population accessing an LTSS service that received a PCP visit in the same year	LTSS-PCP Visits MMIS reports	2013	N/A
56	Percentage of the population accessing an LTSS service and a behavioral health visit in the same year	LTSS and BH MMIS reports	2013	N/A
57	Percentage of the population with behavioral health needs with an ER Visit by type of ER visit	BH Population with ED Visits MMIS reports	2013	N/A
58	Percentage of the population with LTSS needs with an ER visit by type of ER visit	LTSS Population with ED Visits MMIS reports	2013	N/A
59	Percentage of the population at risk for nursing facility placement who remain in the community	MAD SFY Reports	SFY 2013	N/A
60	Number and percentage of members who accessed a behavioral health service that also accessed HCBS in the same year	BH Population with HCBS MMIS reports	2013	N/A
61	Number and percentage of members who maintain their care coordination level, moved to a lower care coordination level, or moved to a higher care coordination level	MCO ad hoc care coordination reports	2014	N/A
62	Percentage of the population accessing a behavioral health service that also received an	BH Clients with Outpatient	2013	N/A

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
	outpatient ambulatory visit in the same year	Ambulatory Visits MMIS reports		
63	Diabetes screening for members with schizophrenia or bipolar disorder who are using antipsychotic medications	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
64	Diabetes monitoring for members with diabetes and schizophrenia	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
65	Total program expenditures	CMS-64 Schedule C	STC	N/A
66	Costs per member	CMS-64 Schedule C (Cost and Member Months)	STC	N/A
67	Costs per user of services	CMS-64 Schedule C (Cost and Member Months); Cost per user of service MMIS reports	STC	N/A
68	Utilization by category of service	FIN Reports	2014	N/A
69	Hospital costs	FIN Reports	2014	N/A
70	Use of HCBS	FIN Reports	2014	N/A
71	Use of institutional care (skilled nursing facilities)	FIN Reports	2014	N/A
72	Use of mental health services	FIN Reports	2014	N/A
73	Use of substance abuse services	FIN Reports	2014	N/A
74	Use of pharmacy services	FIN Reports	2014	N/A
75	Inpatient services exceeding $50,000	FIN Reports	2014	N/A
76	Diagnostic imaging costs	FIN Reports	2014	N/A
77	Emergency department use	FIN Reports	2014	N/A
78	All cause readmissions	MMIS reports	2013	N/A
79	Inpatient mental health/substance use services	MMIS reports	2013	N/A
80	Asthma controller medication compliance (children)	MCO HEDIS reports; Finity member rewards data	2013/2014	The NQCA State of Health Quality 2016 Report (for CY 2015)
81	Diabetes - annual recommended tests (A1C, LDL, eye exam, nephropathy exam)	MCO HEDIS reports; Finity member rewards data	2013/2014	The NQCA State of Health Quality 2016 Report (for CY 2015)

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
82	Prenatal program	MCO HEDIS reports; Finity member rewards data	2013/2014	The NQCA State of Health Quality 2016 Report (for CY 2015)
83	Treatment adherence - schizophrenia	MCO HEDIS reports; Finity member rewards data	2013/2014	The NQCA State of Health Quality 2016 Report (for CY 2015)
84	Treatment adherence - bipolar	Finity member rewards data	2014	N/A
85	Osteoporosis management in elderly women - females aged 65+ years	Osteoporosis MMIS reports; Finity member rewards data	2013/2014	N/A
86	Annual dental visit - adult	MCO HEDIS reports; Finity member rewards data	2014/2014	The NQCA State of Health Quality 2016 Report (for CY 2015)
87	Annual dental visit - child	MCO HEDIS reports; Finity member rewards data	2013/2014	The NQCA State of Health Quality 2016 Report (for CY 2015)
88	Number of members spending credits	Finity member rewards data	2014	N/A
88	Percentage of expedited appeals resolved within three business days	MCO reports (HSD 37)	2014	N/A
89	Percentage of grievances resolved within 30 days	MCO reports (HSD 37)	2014	N/A
90	Percentage of appeals by adjudication (upheld)	MCO reports (HSD 37)	2014	N/A
91	Percentage of appeals by adjudication (partially overturned)	MCO reports (HSD 37)	2014	N/A
92	Percentage of appeals by adjudication (overturned in full)	MCO reports (HSD 37)	2014	N/A
93	Number and percentage of calls answered within 30 seconds	MCO HEDIS reports	2013	N/A
94	Number and percentage of participants satisfied with care coordination	MCO CAHPS reports	2013	SPH and Quality Compass benchmarks
95	Rating of personal doctor	MCO CAHPS reports	2013	SPH and Quality Compass benchmarks
96	Rating of health care	MCO CAHPS reports	2013	SPH and Quality

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
				Compass benchmarks
97	How well doctors communicate	MCO CAHPS reports	2013	SPH and Quality Compass benchmarks
98	Customer service satisfaction	MCO CAHPS reports	2013	SPH and Quality Compass benchmarks
99	Rating of specialist seen most often	MCO CAHPS reports	2013	SPH and Quality Compass benchmarks
100	Percentage of clean claims adjudicated in 30/90 days	Provider Payment Timeliness Report; MCO reports (HSD 47); ad hoc MCO claims payment and activity reports	SFY 2013	N/A
101	Percentage of claims denied	Provider Payment Timeliness Report; MCO reports (HSD 47); ad hoc MCO claims payment and activity reports	SFY 2013	N/A
102	Dollar accuracy rate	MCO reports (HSD 46); ad hoc MCO claims payment and activity reports	2014	N/A
103	Percentage of grievances resolved on time	MCO reports (HSD 37)	2014	N/A
104	Percentage of provider appeals resolved on time	MCO reports (HSD 37)	2014	N/A
105	Provider satisfaction survey results	N/A	2014	N/A
106	Number of eligible providers receiving Electronic Health Record (EHR) incentive payments	Ad hoc EHR program report	2013	N/A
107	Use of different care delivery models, such as number of Health Home participants	N/A	N/A	N/A
108	Percentage of claims paid accurately	MCO reports (HSD 46); ad hoc MCO claims payment and activity reports	2014	N/A
109	PCMH Membership and Hospital/ER Utilization (Use and Outcomes of Payment Reforms)	MCO reports (HSD 48)	2014	N/A

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
110	Number and percentage of visits in compliance with Electronic Visit Verification (EVV) system requirement	N/A	N/A	N/A
111	Adoption of electronic case management/care coordination system	N/A	2014	N/A

C. Statistical Significance and Hypothesis Testing

As part of the Evaluation process, hypothesis testing was performed on measures where available data was deemed adequate and appropriate for such testing. Hypothesis tests are employed to help indicate if an observed change over time was statistically significant. These tests are often applied to HEDIS data when analyzing changes in rates over time, but can be employed on other data sets as appropriate. Although statistical significance does not prove "meaningful improvement," it does help to indicate whether improvement occurred. Furthermore, tests for statistical significance help to indicate how likely it is that intervention caused the improvement as opposed to chance.

For measures that are rates or proportions, a two-sided, pooled proportion z-test was performed to determine whether the hypothesized difference between rates is significantly different from observed sample differences. A significance level of .05 was used in these tests.

The null hypothesis in a given test was that the rate in one year was equal to the rate in the comparison year, and the null hypothesis was rejected when the calculated test statistic was less than .05.

To perform these tests, an implicit assumption was made that the rates derived from the sample populations were independent between years. In addition for HEDIS measures, rates are only aggregated across MCOs if they were reported under the same methodology (Administrative vs. Hybrid) for statistical significance testing. Refer to Appendix A for detailed calculation methodology for each measure.

Note: Cells with blue font in the below tables indicate a statistically significant change using a two-sided pooled proportion z-test

Access to Preventive/Ambulatory Health Services among Centennial Care Enrollees in Aggregate and in Subgroups (Measure 1)

	Baseline	DY1		DY2		Baseline to DY2
Access to preventive/ambulatory health services among Centennial Care enrollees in aggregate and within subgroups	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Access to preventive/ambulatory health services (20-44 Yrs)	84.5%	79.9%	-5.5%	75.8%	-5.2%	-10.4%
Access to preventive/ambulatory health services (45-64 Yrs)	87.3%	85.8%	-1.7%	81.2%	-5.4%	-7.0%
Access to preventive/ambulatory health services (65+ Yrs)	90.0%	88.4%	-1.8%	87.4%	-1.1%	-2.8%
Access to preventive/ambulatory health services (Total)	85.3%	81.9%	-3.9%	77.7%	-5.1%	-8.8%
Molina Healthcare of New Mexico, Inc.						
Access to preventive/ambulatory health services (20-44 Yrs)	82.2%	76.3%	-7.2%	73.6%	-3.5%	-10.4%
Access to preventive/ambulatory health services (45-64 Yrs)	86.4%	84.8%	-1.9%	81.9%	-3.4%	-5.2%
Access to preventive/ambulatory health services (65+ Yrs)	91.4%	86.8%	-5.0%	39.8%	-54.1%	-56.4%
Access to preventive/ambulatory health services (Total)	83.5%	79.5%	-4.8%	76.1%	-4.3%	-8.8%
Blue Cross and Blue Shield of New Mexico						
Access to preventive/ambulatory health services (20-44 Yrs)	81.0%	71.9%	-11.3%	72.4%	0.6%	-10.7%
Access to preventive/ambulatory health services (45-64 Yrs)	86.1%	82.2%	-4.5%	81.6%	-0.7%	-5.2%
Access to preventive/ambulatory health services (65+ Yrs)	NR	85.9%	N/A	89.6%	4.4%	N/A
Access to preventive/ambulatory health services (Total)	82.5%	76.6%	-7.1%	76.4%	-0.3%	-7.4%
United Healthcare of New Mexico, Inc.						
Access to preventive/ambulatory health services (20-44 Yrs)	96.2%	78.7%	-18.1%	75.3%	-4.3%	-21.7%
Access to preventive/ambulatory health services (45-64 Yrs)	99.1%	90.8%	-8.3%	88.0%	-3.1%	-11.1%
Access to preventive/ambulatory health services (65+ Yrs)	97.2%	96.3%	-0.9%	96.9%	0.6%	-0.3%
Access to preventive/ambulatory health services (Total)	98.2%	87.2%	-11.2%	83.5%	-4.3%	-15.0%
Total						
Access to preventive/ambulatory health services (20-44 Yrs)	83.9%	77.3%	-7.8%	74.2%	-4.0%	-11.5%
Access to preventive/ambulatory health services (45-64 Yrs)	89.0%	86.1%	-3.3%	83.0%	-3.6%	-6.8%
Access to preventive/ambulatory health services (65+ Yrs)	93.8%	91.9%	-2.0%	91.4%	-0.6%	-2.6%
Access to preventive/ambulatory health services (Total)	85.5%	81.4%	-4.8%	78.1%	-4.1%	-8.7%

Mental Health Services Utilization (Measure 2)

	DY1	DY2	
Mental health services utilization	**Rate, p_1**	**Rate, p_2**	**Change (p_2/p_1-1)**
Presbyterian Health Plan			
Mental Health Utilization (0-12 Yrs, Male)	12.2%	11.6%	-4.4%
Mental Health Utilization (0-12 Yrs, Female)	8.9%	8.7%	-2.1%
Mental Health Utilization (0-12 Yrs, Total)	10.6%	10.2%	-3.4%
Mental Health Utilization (13-17 Yrs, Male)	18.0%	17.1%	-5.0%
Mental Health Utilization (13-17 Yrs, Female)	19.4%	19.1%	-1.4%
Mental Health Utilization (13-17 Yrs, Total)	18.7%	18.1%	-3.2%
Mental Health Utilization (18-64 Yrs, Male)	16.0%	14.4%	-9.9%
Mental Health Utilization (18-64 Yrs, Female)	16.5%	16.9%	2.0%
Mental Health Utilization (18-64 Yrs, Total)	16.3%	15.9%	-2.5%
Mental Health Utilization (65+ Yrs, Male)	7.9%	8.6%	8.9%
Mental Health Utilization (65+ Yrs, Female)	10.2%	12.0%	17.7%
Mental Health Utilization (65+ Yrs, Total)	9.4%	10.8%	15.0%
Mental Health Utilization (Total, Male)	14.3%	13.5%	-5.4%
Mental Health Utilization (Total, Female)	13.8%	14.1%	2.3%
Mental Health Utilization (Grand Total)	14.0%	13.8%	-1.2%
Molina Healthcare of New Mexico, Inc.			
Mental Health Utilization (0-12 Yrs, Male)	9.9%	9.7%	-2.9%
Mental Health Utilization (0-12 Yrs, Female)	7.3%	7.4%	1.6%
Mental Health Utilization (0-12 Yrs, Total)	8.7%	8.6%	-1.0%
Mental Health Utilization (13-17 Yrs, Male)	16.5%	16.5%	0.4%
Mental Health Utilization (13-17 Yrs, Female)	18.1%	17.9%	-1.3%
Mental Health Utilization (13-17 Yrs, Total)	17.3%	17.2%	-0.5%
Mental Health Utilization (18-64 Yrs, Male)	14.6%	14.2%	-3.0%
Mental Health Utilization (18-64 Yrs, Female)	15.1%	16.2%	7.4%
Mental Health Utilization (18-64 Yrs, Total)	14.9%	15.4%	3.1%
Mental Health Utilization (65+ Yrs, Male)	8.8%	8.9%	0.9%
Mental Health Utilization (65+ Yrs, Female)	11.3%	10.1%	-10.5%
Mental Health Utilization (65+ Yrs, Total)	10.4%	9.6%	-7.1%
Mental Health Utilization (Total, Male)	12.5%	12.5%	-0.6%
Mental Health Utilization (Total, Female)	12.4%	13.1%	5.7%
Mental Health Utilization (Grand Total)	12.5%	12.8%	2.8%
Blue Cross and Blue Shield of New Mexico			
Mental Health Utilization (0-12 Yrs, Male)	10.9%	8.9%	-18.3%
Mental Health Utilization (0-12 Yrs, Female)	7.8%	6.6%	-15.7%
Mental Health Utilization (0-12 Yrs, Total)	9.4%	7.8%	-17.2%
Mental Health Utilization (13-17 Yrs, Male)	18.2%	15.5%	-15.2%
Mental Health Utilization (13-17 Yrs, Female)	20.9%	17.6%	-16.0%
Mental Health Utilization (13-17 Yrs, Total)	19.5%	16.5%	-15.5%
Mental Health Utilization (18-64 Yrs, Male)	18.1%	15.4%	-14.9%
Mental Health Utilization (18-64 Yrs, Female)	19.3%	17.5%	-9.2%
Mental Health Utilization (18-64 Yrs, Total)	18.7%	16.5%	-11.9%
Mental Health Utilization (65+ Yrs, Male)	15.3%	12.8%	-16.2%
Mental Health Utilization (65+ Yrs, Female)	18.4%	15.4%	-16.3%
Mental Health Utilization (65+ Yrs, Total)	17.2%	14.4%	-16.2%
Mental Health Utilization (Total, Male)	15.6%	13.3%	-14.6%
Mental Health Utilization (Total, Female)	16.0%	14.4%	-10.1%
Mental Health Utilization (Grand Total)	15.8%	13.9%	-12.3%

Mental Health Services Utilization (Continued)

Mental health services utilization	DY1 Rate, p_1	DY2 Rate, p_2	DY2 Change (p_2/p_1-1)
United Healthcare of New Mexico, Inc.			
Mental Health Utilization (0-12 Yrs, Male)	9.6%	8.2%	-14.1%
Mental Health Utilization (0-12 Yrs, Female)	6.9%	5.6%	-17.8%
Mental Health Utilization (0-12 Yrs, Total)	8.3%	7.0%	-15.4%
Mental Health Utilization (13-17 Yrs, Male)	17.6%	15.6%	-11.7%
Mental Health Utilization (13-17 Yrs, Female)	18.4%	17.0%	-7.5%
Mental Health Utilization (13-17 Yrs, Total)	18.0%	16.3%	-9.5%
Mental Health Utilization (18-64 Yrs, Male)	17.5%	16.8%	-3.8%
Mental Health Utilization (18-64 Yrs, Female)	19.3%	19.1%	-1.0%
Mental Health Utilization (18-64 Yrs, Total)	18.5%	18.0%	-2.5%
Mental Health Utilization (65+ Yrs, Male)	10.3%	9.4%	-9.1%
Mental Health Utilization (65+ Yrs, Female)	11.6%	11.0%	-5.0%
Mental Health Utilization (65+ Yrs, Total)	11.2%	10.5%	-6.2%
Mental Health Utilization (Total, Male)	15.6%	14.7%	-5.8%
Mental Health Utilization (Total, Female)	16.4%	15.9%	-3.2%
Mental Health Utilization (Grand Total)	16.0%	15.3%	-4.5%

Total			
Mental Health Utilization (0-12 Yrs, Male)	11.0%	10.2%	-6.9%
Mental Health Utilization (0-12 Yrs, Female)	8.0%	7.7%	-4.1%
Mental Health Utilization (0-12 Yrs, Total)	9.5%	9.0%	-5.7%
Mental Health Utilization (13-17 Yrs, Male)	17.4%	16.6%	-4.8%
Mental Health Utilization (13-17 Yrs, Female)	19.0%	18.3%	-3.6%
Mental Health Utilization (13-17 Yrs, Total)	18.2%	17.5%	-4.1%
Mental Health Utilization (18-64 Yrs, Male)	16.3%	15.1%	-7.5%
Mental Health Utilization (18-64 Yrs, Female)	16.9%	17.2%	1.4%
Mental Health Utilization (18-64 Yrs, Total)	16.7%	16.3%	-2.4%
Mental Health Utilization (65+ Yrs, Male)	10.4%	10.0%	-3.6%
Mental Health Utilization (65+ Yrs, Female)	12.3%	12.1%	-1.5%
Mental Health Utilization (65+ Yrs, Total)	11.7%	11.4%	-2.1%
Mental Health Utilization (Total, Male)	14.0%	13.3%	-5.2%
Mental Health Utilization (Total, Female)	13.9%	14.1%	1.1%
Mental Health Utilization (Grand Total)	13.9%	13.7%	-1.8%

Number and percentage of people with an annual dental visit (Measure 6)[165]

	Baseline	DY1		DY2		Baseline to DY2
Annual dental visit	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Annual Dental Visit (2-3 Yrs)	55.6%	54.4%	-2.3%	52.9%	-2.6%	-4.8%
Annual Dental Visit (4-6 Yrs)	75.0%	73.2%	-2.5%	71.7%	-2.1%	-4.5%
Annual Dental Visit (7-10 Yrs)	79.1%	76.7%	-3.0%	75.0%	-2.3%	-5.3%
Annual Dental Visit (11-14 Yrs)	74.1%	72.6%	-2.0%	70.6%	-2.8%	-4.8%
Annual Dental Visit (15-18 Yrs)	64.3%	61.9%	-3.7%	61.5%	-0.7%	-4.3%
Annual Dental Visit (19-21 Yrs)	44.2%	39.3%	-11.1%	41.2%	4.8%	-6.9%
Annual Dental Visit (Total)	71.0%	68.1%	-4.1%	66.4%	-2.5%	-6.5%
Molina Healthcare of New Mexico, Inc.						
Annual Dental Visit (2-3 Yrs)	55.6%	51.1%	-8.1%	57.8%	13.2%	4.1%
Annual Dental Visit (4-6 Yrs)	74.3%	67.8%	-8.6%	74.8%	10.2%	0.7%
Annual Dental Visit (7-10 Yrs)	78.9%	71.0%	-10.0%	78.3%	10.2%	-0.8%
Annual Dental Visit (11-14 Yrs)	74.2%	66.2%	-10.9%	74.7%	12.9%	0.6%
Annual Dental Visit (15-18 Yrs)	64.0%	57.1%	-10.9%	65.1%	14.1%	1.7%
Annual Dental Visit (19-21 Yrs)	45.9%	35.5%	-22.8%	43.6%	22.9%	-5.2%
Annual Dental Visit (Total)	70.9%	62.7%	-11.5%	70.1%	11.7%	-1.2%
Blue Cross and Blue Shield of New Mexico						
Annual Dental Visit (2-3 Yrs)	56.5%	47.8%	-15.4%	48.8%	2.0%	-13.6%
Annual Dental Visit (4-6 Yrs)	73.3%	63.3%	-13.7%	65.2%	3.1%	-11.1%
Annual Dental Visit (7-10 Yrs)	75.5%	66.9%	-11.3%	68.1%	1.7%	-9.8%
Annual Dental Visit (11-14 Yrs)	68.1%	61.4%	-9.9%	63.5%	3.4%	-6.8%
Annual Dental Visit (15-18 Yrs)	59.1%	51.4%	-13.0%	55.2%	7.3%	-6.6%
Annual Dental Visit (19-21 Yrs)	41.0%	29.6%	-27.8%	37.1%	25.2%	-9.7%
Annual Dental Visit (Total)	66.8%	57.5%	-14.0%	59.6%	3.8%	-10.7%
United Healthcare of New Mexico, Inc.						
Annual Dental Visit (2-3 Yrs)	NR	36.4%	N/A	41.8%	14.6%	N/A
Annual Dental Visit (4-6 Yrs)	NR	51.3%	N/A	58.4%	13.9%	N/A
Annual Dental Visit (7-10 Yrs)	NR	54.8%	N/A	59.2%	8.0%	N/A
Annual Dental Visit (11-14 Yrs)	NR	48.8%	N/A	54.6%	12.0%	N/A
Annual Dental Visit (15-18 Yrs)	NR	39.9%	N/A	42.3%	6.2%	N/A
Annual Dental Visit (19-21 Yrs)	NR	25.9%	N/A	28.6%	10.4%	N/A
Annual Dental Visit (Total)	51.5%	41.5%	-19.4%	49.9%	20.1%	-3.2%
Total						
Annual Dental Visit (2-3 Yrs)	55.7%	51.6%	-7.5%	53.5%	3.8%	-4.0%
Annual Dental Visit (4-6 Yrs)	74.6%	69.3%	-7.1%	71.1%	2.7%	-4.7%
Annual Dental Visit (7-10 Yrs)	78.7%	72.9%	-7.4%	74.6%	2.3%	-5.2%
Annual Dental Visit (11-14 Yrs)	73.6%	68.4%	-7.1%	70.4%	3.0%	-4.3%
Annual Dental Visit (15-18 Yrs)	63.8%	58.5%	-8.3%	61.0%	4.4%	-4.3%
Annual Dental Visit (19-21 Yrs)	44.4%	34.9%	-21.5%	40.4%	15.9%	-9.0%
Annual Dental Visit (Total)	70.6%	64.0%	-9.3%	66.0%	3.1%	-6.5%

Enrollment in Centennial Care as a Percentage of State Population (Measure 7)

	DY1	DY2		DY3		DY1 to DY3
Enrollment in Centennial Care as a Percentage of State Population	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Total						
Enrollment in Centennial Care as a Percentage of State Population	27.3%	31.0%	13.3%	32.7%	5.6%	19.6%

[165] UHC baseline numerator and denominator were included in the calculation of aggregate rates; "NR" is shown since the denominator was less than 30.

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

	DY1		DY2		DY1 to DY3
Number and percentage of participants with BH conditions who accessed any of the three new BH services (respite, family support and recovery)	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_3/p_1-1)**
Total					
Number and percentage of participants with BH conditions who accessed any of the three new BH services (respite, family support and recovery)	1.02%	N/A	1.10%	7.82%	16.90%

Number and percentage of Unduplicated Participants with at Least One PCP Visit (Measure 11)

	Baseline	DY1		DY2		DY3		Baseline to DY3
Number and percentage of unduplicated participants with at least one PCP visit, in aggregate and among subgroups	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Change (p_2/p_0-1)**
Total								
Number and percentage of unduplicated participants with at least one PCP visit, in aggregate and among subgroups	65.5%	57.6%	-12.1%	50.4%	-12.6%	47.4%	-5.8%	-27.7%

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

	DY1		DY2	
Number and percentage of substance use disorder participants with follow-up 7 and 30 days after leaving RTC	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**
Presbyterian Health Plan				
Percent of Members Seen for Follow-Up within 7 Days of Discharge from RTC	43.0%	N/A	27.1%	-37.0%
Percent of Members Seen for Follow-Up within 30 Days of Discharge from RTC	64.7%	N/A	47.7%	-26.3%
Molina Healthcare of New Mexico, Inc.				
Percent of Members Seen for Follow-Up within 7 Days of Discharge from RTC	13.6%	N/A	24.9%	82.8%
Percent of Members Seen for Follow-Up within 30 Days of Discharge from RTC	22.0%	N/A	41.0%	86.3%
Blue Cross and Blue Shield of New Mexico				
Percent of Members Seen for Follow-Up within 7 Days of Discharge from RTC	13.8%	N/A	11.5%	-16.7%
Percent of Members Seen for Follow-Up within 30 Days of Discharge from RTC	30.3%	N/A	28.7%	-5.3%
United Healthcare of New Mexico, Inc.				
Percent of Members Seen for Follow-Up within 7 Days of Discharge from RTC	NR	N/A	58.1%	N/A
Percent of Members Seen for Follow-Up within 30 Days of Discharge from RTC	NR	N/A	74.2%	N/A
Total				
Percent of Members Seen for Follow-Up within 7 Days of Discharge from RTC	26.5%	N/A	25.7%	-3.1%
Percent of Members Seen for Follow-Up within 30 Days of Discharge from RTC	43.2%	N/A	44.0%	1.9%

Follow-up after Hospitalization of Mental Illness (Measure 15)[166]

	DY1	DY2	
Number and percentage of BH participants with follow-up after hospitalization of mental illness	**Rate, p_1**	**Rate, p_2**	**Change (p_2/p_1-1)**
Presbyterian Health Plan			
Follow-Up After Hospitalization for Mental Illness (30-day)	67.9%	59.7%	-12.0%
Follow-Up After Hospitalization for Mental Illness (7-day)	43.1%	32.6%	-24.5%
Molina Healthcare of New Mexico, Inc.			
Follow-Up After Hospitalization for Mental Illness (30-day)	64.8%	59.8%	-7.8%
Follow-Up After Hospitalization for Mental Illness (7-day)	41.8%	34.6%	-17.1%
Blue Cross and Blue Shield of New Mexico			
Follow-Up After Hospitalization for Mental Illness (30-day)	58.5%	55.1%	-5.8%
Follow-Up After Hospitalization for Mental Illness (7-day)	39.0%	34.3%	-12.1%
United Healthcare of New Mexico, Inc.			
Follow-Up After Hospitalization for Mental Illness (30-day)	71.0%	73.1%	2.9%
Follow-Up After Hospitalization for Mental Illness (7-day)	55.2%	55.0%	-0.4%
Total			
Follow-Up After Hospitalization for Mental Illness (30-day)	65.3%	60.9%	-6.9%
Follow-Up After Hospitalization for Mental Illness (7-day)	43.8%	37.6%	-14.2%

[166] DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Childhood Immunization Status (Measure 16)

	Baseline	DY1		DY2		Baseline to DY2
Childhood Immunization Status	Rate, p_0	Rate, p_1	Change (p_1/p_0-1)	Rate, p_2	Change (p_2/p_1-1)	Change (p_2/p_0-1)
Presbyterian Health Plan						
Childhood Immunization Status (DTaP)	77.3%	79.2%	2.4%	75.9%	-4.1%	-1.8%
Childhood Immunization Status (IPV)	88.0%	88.0%	0.0%	87.3%	-0.8%	-0.8%
Childhood Immunization Status (MMR)	87.5%	91.2%	4.2%	85.2%	-6.6%	-2.6%
Childhood Immunization Status (HiB)	90.0%	90.3%	0.3%	87.3%	-3.3%	-3.1%
Childhood Immunization Status (Hepatitis B)	79.2%	81.3%	2.6%	83.8%	3.1%	5.8%
Childhood Immunization Status (VZV)	88.0%	90.5%	2.9%	85.0%	-6.1%	-3.4%
Childhood Immunization Status (Pneumo- coccal Conjugate)	80.6%	78.0%	-3.2%	76.4%	-2.1%	-5.2%
Childhood Immunization Status (Hepatitis A)	86.1%	87.3%	1.3%	84.5%	-3.2%	-1.9%
Childhood Immunization Status (Rotavirus)	73.1%	75.5%	3.2%	75.9%	0.6%	3.8%
Childhood Immunization Status (Influenza)	57.2%	53.9%	-5.7%	52.1%	-3.4%	-8.9%
Childhood Immunization Status (Combination 2)	67.4%	69.4%	3.1%	69.7%	0.3%	3.4%
Childhood Immunization Status (Combination 3)	66.0%	64.6%	-2.1%	66.4%	2.9%	0.7%
Childhood Immunization Status (Combination 4)	63.0%	61.8%	-1.8%	65.0%	5.2%	3.3%
Childhood Immunization Status (Combination 5)	57.6%	56.5%	-2.0%	59.7%	5.7%	3.6%
Childhood Immunization Status (Combination 6)	44.4%	39.1%	-12.0%	44.0%	12.4%	-1.0%
Childhood Immunization Status (Combination 7)	55.8%	54.4%	-2.5%	58.3%	7.2%	4.6%
Childhood Immunization Status (Combination 8)	43.1%	38.2%	-11.3%	43.5%	13.9%	1.1%
Childhood Immunization Status (Combination 9)	39.4%	35.2%	-10.6%	39.4%	11.8%	0.0%
Childhood Immunization Status (Combination 10)	38.7%	34.5%	-10.8%	38.9%	12.8%	0.6%
Molina Healthcare of New Mexico, Inc.						
Childhood Immunization Status (DTaP)	81.9%	83.0%	1.3%	70.6%	-14.9%	-13.7%
Childhood Immunization Status (IPV)	92.5%	93.2%	0.7%	84.8%	-9.0%	-8.4%
Childhood Immunization Status (MMR)	92.1%	93.4%	1.4%	87.2%	-6.6%	-5.3%
Childhood Immunization Status (HiB)	92.3%	93.2%	1.0%	83.9%	-10.0%	-9.1%
Childhood Immunization Status (Hepatitis B)	92.1%	92.9%	1.0%	84.8%	-8.8%	-7.9%
Childhood Immunization Status (VZV)	92.3%	92.9%	0.7%	86.3%	-7.1%	-6.5%
Childhood Immunization Status (Pneumo- coccal Conjugate)	80.1%	82.6%	3.0%	71.5%	-13.4%	-10.7%
Childhood Immunization Status (Hepatitis A)	87.9%	89.6%	2.0%	83.4%	-6.9%	-5.0%
Childhood Immunization Status (Rotavirus)	72.6%	76.4%	5.2%	67.8%	-11.3%	-6.7%
Childhood Immunization Status (Influenza)	53.6%	54.5%	1.6%	41.9%	-23.1%	-21.8%
Childhood Immunization Status (Combination 2)	78.6%	80.8%	2.8%	67.1%	-16.9%	-14.6%
Childhood Immunization Status (Combination 3)	73.3%	77.7%	6.0%	64.7%	-16.8%	-11.7%
Childhood Immunization Status (Combination 4)	71.1%	75.1%	5.6%	62.0%	-17.4%	-12.7%
Childhood Immunization Status (Combination 5)	59.6%	66.4%	11.5%	57.8%	-13.0%	-3.0%
Childhood Immunization Status (Combination 6)	46.1%	50.3%	9.1%	35.3%	-29.8%	-23.4%
Childhood Immunization Status (Combination 7)	57.8%	64.2%	11.1%	55.4%	-13.7%	-4.2%
Childhood Immunization Status (Combination 8)	45.5%	49.4%	8.7%	34.7%	-29.9%	-23.8%
Childhood Immunization Status (Combination 9)	40.4%	45.7%	13.1%	32.7%	-28.5%	-19.1%
Childhood Immunization Status (Combination 10)	39.7%	44.8%	12.8%	32.0%	-28.6%	-19.4%

Childhood Immunization Status (Continued)

	Baseline	DY1		DY2		Baseline to DY2
Childhood Immunization Status	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Blue Cross and Blue Shield of New Mexico						
Childhood Immunization Status (DTaP)	81.8%	80.6%	-1.5%	72.6%	-9.9%	-11.2%
Childhood Immunization Status (IPV)	92.2%	92.7%	0.5%	86.3%	-6.9%	-6.4%
Childhood Immunization Status (MMR)	91.8%	90.5%	-1.4%	87.0%	-3.9%	-5.3%
Childhood Immunization Status (HiB)	92.0%	92.9%	1.0%	85.0%	-8.6%	-7.6%
Childhood Immunization Status (Hepatitis B)	91.4%	92.7%	1.5%	87.2%	-6.0%	-4.5%
Childhood Immunization Status (VZV)	92.7%	90.1%	-2.8%	87.0%	-3.4%	-6.2%
Childhood Immunization Status (Pneumo- coccal Conjugate)	80.0%	80.8%	0.9%	74.0%	-8.5%	-7.6%
Childhood Immunization Status (Hepatitis A)	87.1%	88.5%	1.6%	83.9%	-5.2%	-3.7%
Childhood Immunization Status (Rotavirus)	74.1%	74.8%	1.0%	68.7%	-8.3%	-7.3%
Childhood Immunization Status (Influenza)	52.8%	51.4%	-2.5%	52.8%	2.6%	0.0%
Childhood Immunization Status (Combination 2)	78.3%	76.8%	-1.9%	70.9%	-7.8%	-9.5%
Childhood Immunization Status (Combination 3)	73.8%	74.4%	0.8%	67.8%	-8.9%	-8.2%
Childhood Immunization Status (Combination 4)	71.8%	73.1%	1.7%	65.8%	-10.0%	-8.4%
Childhood Immunization Status (Combination 5)	62.3%	63.4%	1.7%	57.4%	-9.4%	-7.9%
Childhood Immunization Status (Combination 6)	45.9%	45.7%	-0.4%	45.9%	0.5%	0.0%
Childhood Immunization Status (Combination 7)	61.4%	62.7%	2.1%	55.6%	-11.3%	-9.4%
Childhood Immunization Status (Combination 8)	45.0%	45.7%	1.5%	44.4%	-2.9%	-1.4%
Childhood Immunization Status (Combination 9)	39.9%	40.4%	1.2%	39.1%	-3.3%	-2.1%
Childhood Immunization Status (Combination 10)	39.2%	40.4%	2.9%	37.7%	-6.6%	-3.8%
United Healthcare of New Mexico, Inc.						
Childhood Immunization Status (DTaP)	NR	65.7%	N/A	51.3%	-21.9%	N/A
Childhood Immunization Status (IPV)	NR	74.3%	N/A	62.5%	-15.8%	N/A
Childhood Immunization Status (MMR)	NR	80.0%	N/A	71.8%	-10.3%	N/A
Childhood Immunization Status (HiB)	NR	75.7%	N/A	64.7%	-14.5%	N/A
Childhood Immunization Status (Hepatitis B)	NR	74.3%	N/A	60.8%	-18.1%	N/A
Childhood Immunization Status (VZV)	NR	80.0%	N/A	71.3%	-10.9%	N/A
Childhood Immunization Status (Pneumo- coccal Conjugate)	NR	67.1%	N/A	50.1%	-25.4%	N/A
Childhood Immunization Status (Hepatitis A)	NR	75.7%	N/A	72.5%	-4.2%	N/A
Childhood Immunization Status (Rotavirus)	NR	64.3%	N/A	44.3%	-31.1%	N/A
Childhood Immunization Status (Influenza)	NR	41.4%	N/A	34.8%	-16.0%	N/A
Childhood Immunization Status (Combination 2)	NR	60.0%	N/A	47.0%	-21.7%	N/A
Childhood Immunization Status (Combination 3)	NR	58.6%	N/A	43.6%	-25.6%	N/A
Childhood Immunization Status (Combination 4)	NR	55.7%	N/A	43.1%	-22.7%	N/A
Childhood Immunization Status (Combination 5)	NR	51.4%	N/A	34.3%	-33.3%	N/A
Childhood Immunization Status (Combination 6)	NR	31.4%	N/A	26.0%	-17.2%	N/A
Childhood Immunization Status (Combination 7)	NR	48.6%	N/A	33.8%	-30.4%	N/A
Childhood Immunization Status (Combination 8)	NR	31.4%	N/A	26.0%	-17.2%	N/A
Childhood Immunization Status (Combination 9)	NR	25.7%	N/A	22.4%	-12.9%	N/A
Childhood Immunization Status (Combination 10)	NR	25.7%	N/A	22.4%	-12.9%	N/A

Childhood Immunization Status (Continued)

Childhood Immunization Status	Baseline	DY1		DY2		Baseline to DY2
	Rate, p_0	Rate, p_1	Change (p_1/p_0-1)	Rate, p_2	Change (p_2/p_1-1)	Change (p_2/p_0-1)
Total						
Childhood Immunization Status (DTaP)	80.4%	80.2%	-0.3%	67.9%	-15.3%	-15.5%
Childhood Immunization Status (IPV)	90.9%	90.5%	-0.5%	80.6%	-11.0%	-11.4%
Childhood Immunization Status (MMR)	90.5%	91.1%	0.7%	83.0%	-8.9%	-8.3%
Childhood Immunization Status (HiB)	91.5%	91.3%	-0.1%	80.5%	-11.9%	-12.0%
Childhood Immunization Status (Hepatitis B)	87.6%	88.4%	0.8%	79.5%	-10.0%	-9.3%
Childhood Immunization Status (VZV)	91.0%	90.6%	-0.4%	82.6%	-8.8%	-9.2%
Childhood Immunization Status (Pneumo- coccal Conjugate)	80.2%	79.8%	-0.5%	68.3%	-14.4%	-14.8%
Childhood Immunization Status (Hepatitis A)	87.1%	87.9%	0.9%	81.2%	-7.5%	-6.7%
Childhood Immunization Status (Rotavirus)	73.3%	75.0%	2.3%	64.5%	-14.0%	-12.0%
Childhood Immunization Status (Influenza)	54.5%	52.7%	-3.3%	45.6%	-13.5%	-16.4%
Childhood Immunization Status (Combination 2)	74.9%	75.0%	0.2%	64.0%	-14.7%	-14.5%
Childhood Immunization Status (Combination 3)	71.1%	71.7%	0.8%	60.9%	-14.9%	-14.3%
Childhood Immunization Status (Combination 4)	68.7%	69.4%	1.0%	59.3%	-14.6%	-13.7%
Childhood Immunization Status (Combination 5)	59.9%	61.6%	3.0%	52.7%	-14.6%	-12.1%
Childhood Immunization Status (Combination 6)	45.5%	44.5%	-2.3%	38.0%	-14.5%	-16.5%
Childhood Immunization Status (Combination 7)	58.4%	59.9%	2.7%	51.1%	-14.7%	-12.4%
Childhood Immunization Status (Combination 8)	44.5%	43.9%	-1.4%	37.3%	-14.9%	-16.2%
Childhood Immunization Status (Combination 9)	39.9%	39.8%	-0.3%	33.6%	-15.6%	-15.9%
Childhood Immunization Status (Combination 10)	39.2%	39.3%	0.1%	32.9%	-16.1%	-16.0%

Immunizations for Adolescents (Measure 17)[167]

Immunizations for Adolescents	Baseline	DY1		DY2		Baseline to DY2
	Rate, p_0	Rate, p_1	Change (p_1/p_0-1)	Rate, p_2	Change (p_2/p_1-1)	Change (p_2/p_0-1)
Presbyterian Health Plan						
Immunizations for Adolescents (Meningococcal)	67.8%	67.1%	-1.1%	60.4%	-10.0%	-10.9%
Immunizations for Adolescents (Tdap/Td)	78.9%	78.7%	-0.3%	73.9%	-6.1%	-6.3%
Immunizations for Adolescents (Combination 1)	63.4%	64.9%	2.2%	58.9%	-9.2%	-7.1%
Molina Healthcare of New Mexico, Inc.						
Immunizations for Adolescents (Meningococcal)	62.3%	63.9%	2.6%	76.2%	19.2%	22.3%
Immunizations for Adolescents (Tdap/Td)	78.5%	75.9%	-3.3%	85.4%	12.6%	8.9%
Immunizations for Adolescents (Combination 1)	60.2%	61.1%	1.6%	73.8%	20.8%	22.7%
Blue Cross and Blue Shield of New Mexico						
Immunizations for Adolescents (Meningococcal)	NR	39.1%	N/A	39.2%	0.2%	N/A
Immunizations for Adolescents (Tdap/Td)	NR	42.2%	N/A	43.5%	3.2%	N/A
Immunizations for Adolescents (Combination 1)	NR	33.9%	N/A	34.6%	2.0%	N/A
United Healthcare of New Mexico, Inc.						
Immunizations for Adolescents (Meningococcal)	NR	33.3%	N/A	43.6%	30.7%	N/A
Immunizations for Adolescents (Tdap/Td)	NR	53.3%	N/A	49.4%	-7.4%	N/A
Immunizations for Adolescents (Combination 1)	NR	33.3%	N/A	40.6%	21.9%	N/A
Total						
Immunizations for Adolescents (Meningococcal)	65.1%	64.3%	-1.2%	60.3%	-6.3%	-7.3%
Immunizations for Adolescents (Tdap/Td)	78.5%	76.4%	-2.7%	69.8%	-8.6%	-11.1%
Immunizations for Adolescents (Combination 1)	61.6%	61.9%	0.5%	58.1%	-6.2%	-5.8%

[167] UHC baseline numerator and denominator were included in the calculation of aggregate rates; "NR" is shown since the denominator was less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Well-Child Visits in the First 15 Months of Life (Measure 18)[168]

	Baseline	DY1		DY2		Baseline to DY2
Well-child visits in first 15 months of life	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Well-Child Visits in the First 15 Months of Life (6+ Visits)	63.4%	46.5%	-26.6%	48.3%	3.7%	-23.9%
Molina Healthcare of New Mexico, Inc.						
Well-Child Visits in the First 15 Months of Life (6+ Visits)	62.5%	51.8%	-17.2%	55.4%	7.1%	-11.3%
Blue Cross and Blue Shield of New Mexico						
Well-Child Visits in the First 15 Months of Life (6+ Visits)	62.3%	44.3%	-28.8%	47.9%	8.0%	-23.0%
United Healthcare of New Mexico, Inc.						
Well-Child Visits in the First 15 Months of Life (6+ Visits)	NR	NR	N/A	56.9%	N/A	N/A
Total						
Well-Child Visits in the First 15 Months of Life (6+ Visits)	62.7%	46.1%	-26.5%	56.1%	21.7%	-10.5%

[168] DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Well-Child Visits in Third, Fourth, Fifth and Sixth Years of Life (Measure 19)[169]

	Baseline	DY1		DY2		Baseline to DY2
Well-child visits in third, fourth, fifth and sixth years of life	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Well-child visits in third, fourth, fifth and sixth years of life	66.7%	54.9%	-17.6%	54.8%	-0.2%	-17.8%
Molina Healthcare of New Mexico, Inc.						
Well-child visits in third, fourth, fifth and sixth years of life	66.5%	63.6%	-4.4%	68.8%	8.2%	3.5%
Blue Cross and Blue Shield of New Mexico						
Well-child visits in third, fourth, fifth and sixth years of life	60.2%	56.6%	-5.9%	57.6%	1.7%	-4.3%
United Healthcare of New Mexico, Inc.						
Well-child visits in third, fourth, fifth and sixth years of life	NR	65.9%	N/A	52.6%	-20.3%	N/A
Total						
Well-child visits in third, fourth, fifth and sixth years of life	64.3%	64.8%	0.7%	60.8%	-6.1%	-5.5%

Adolescent Well Care Visits (Measure 20)[170]

	Baseline	DY1		DY2		Baseline to DY2
Adolescent well care visits	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Adolescent well care visits	48.1%	36.4%	-24.5%	32.3%	-11.3%	-33.0%
Molina Healthcare of New Mexico, Inc.						
Adolescent well care visits	50.8%	51.7%	1.7%	45.9%	-11.1%	-9.6%
Blue Cross and Blue Shield of New Mexico						
Adolescent well care visits	39.0%	36.3%	-6.8%	33.1%	-8.9%	-15.2%
United Healthcare of New Mexico, Inc.						
Adolescent well care visits	NR	31.1%	N/A	37.2%	19.5%	N/A
Total						
Adolescent well care visits	49.7%	41.9%	-15.6%	41.8%	-0.3%	-15.9%

[169] DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.
[170] UHC baseline numerator and denominator were included in the calculation of aggregate rates; "NR" is shown since the denominator was less than 30.

Prenatal and Postpartum Care (Measure 21)[171]

	Baseline	DY1		DY2		Baseline to DY2
Prenatal and Postpartum Care	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Postpartum Care	57.9%	61.9%	6.9%	53.1%	-14.1%	-8.2%
Timeliness of Prenatal Care	80.0%	77.9%	-2.7%	66.4%	-14.8%	-17.1%
Molina Healthcare of New Mexico, Inc.						
Postpartum Care	62.9%	54.5%	-13.4%	51.5%	-5.5%	-18.1%
Timeliness of Prenatal Care	89.2%	76.8%	-13.9%	76.0%	-1.1%	-14.8%
Blue Cross and Blue Shield of New Mexico						
Postpartum Care	63.1%	54.5%	-13.5%	57.9%	6.2%	-8.2%
Timeliness of Prenatal Care	86.1%	73.1%	-15.1%	72.6%	-0.6%	-15.6%
United Healthcare of New Mexico, Inc.						
Postpartum Care	NR	48.2%	N/A	41.4%	-14.1%	N/A
Timeliness of Prenatal Care	NR	63.7%	N/A	67.4%	5.7%	N/A
Total						
Postpartum Care	61.3%	54.8%	-10.5%	51.2%	-6.7%	-16.5%
Timeliness of Prenatal Care	84.8%	73.0%	-13.9%	70.7%	-3.2%	-16.6%

[171] UHC baseline numerator and denominator were included in the calculation of aggregate rates; "NR" is shown since the denominator was less than 30.

Frequency of Ongoing Prenatal Care (Measure 22)[172]

	Baseline	DY1		DY2		Baseline to DY2
Frequency of Prenatal Care	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Frequency of Ongoing Prenatal Care (<21%)	9.3%	13.6%	47.4%	21.3%	56.4%	130.5%
Frequency of Ongoing Prenatal Care (21-40%)	10.6%	12.5%	17.1%	10.9%	-12.6%	2.4%
Frequency of Ongoing Prenatal Care (41-60%)	9.3%	12.7%	37.2%	10.7%	-16.0%	15.3%
Frequency of Ongoing Prenatal Care (61-80%)	13.9%	12.5%	-10.2%	14.2%	13.5%	1.9%
Frequency of Ongoing Prenatal Care (>= 81%)	56.9%	48.7%	-14.5%	42.9%	-11.9%	-24.6%
Molina Healthcare of New Mexico, Inc.						
Frequency of Ongoing Prenatal Care (<21%)	4.0%	9.0%	124.2%	7.6%	-16.2%	87.9%
Frequency of Ongoing Prenatal Care (21-40%)	3.5%	7.7%	115.9%	7.8%	1.6%	119.4%
Frequency of Ongoing Prenatal Care (41-60%)	5.7%	8.3%	46.9%	10.3%	23.6%	81.5%
Frequency of Ongoing Prenatal Care (61-80%)	13.5%	14.0%	3.6%	19.0%	36.0%	40.9%
Frequency of Ongoing Prenatal Care (>= 81%)	73.3%	61.0%	-16.7%	55.4%	-9.3%	-24.4%
Blue Cross and Blue Shield of New Mexico						
Frequency of Ongoing Prenatal Care (<21%)	7.7%	16.1%	107.4%	11.6%	-27.9%	49.6%
Frequency of Ongoing Prenatal Care (21-40%)	6.0%	7.7%	28.8%	10.7%	39.0%	79.0%
Frequency of Ongoing Prenatal Care (41-60%)	9.3%	6.6%	-29.4%	11.1%	69.7%	19.8%
Frequency of Ongoing Prenatal Care (61-80%)	16.2%	14.5%	-10.3%	16.0%	10.7%	-0.7%
Frequency of Ongoing Prenatal Care (>= 81%)	60.8%	55.2%	-9.3%	50.6%	-8.4%	-16.9%
United Healthcare of New Mexico, Inc.						
Frequency of Ongoing Prenatal Care (<21%)	NR	20.7%	N/A	20.4%	-1.2%	N/A
Frequency of Ongoing Prenatal Care (21-40%)	NR	12.2%	N/A	23.1%	90.0%	N/A
Frequency of Ongoing Prenatal Care (41-60%)	NR	11.2%	N/A	10.5%	-6.5%	N/A
Frequency of Ongoing Prenatal Care (61-80%)	NR	13.4%	N/A	11.9%	-10.9%	N/A
Frequency of Ongoing Prenatal Care (>= 81%)	NR	42.6%	N/A	34.1%	-20.0%	N/A
Total						
Frequency of Ongoing Prenatal Care (<21%)	7.4%	14.8%	100.1%	15.1%	2.4%	104.9%
Frequency of Ongoing Prenatal Care (21-40%)	6.8%	9.9%	45.2%	13.0%	30.5%	89.5%
Frequency of Ongoing Prenatal Care (41-60%)	8.1%	9.6%	19.7%	10.6%	10.5%	32.2%
Frequency of Ongoing Prenatal Care (61-80%)	14.5%	13.6%	-6.4%	15.3%	12.9%	5.7%
Frequency of Ongoing Prenatal Care (>= 81%)	63.2%	52.1%	-17.6%	45.9%	-11.8%	-27.3%

[172] UHC baseline numerators and denominator were included in the calculation of aggregate rates; "NR" is shown since the denominator was less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Breast Cancer Screening for Women (Measure 23)[173]

	Baseline	DY1		DY2		Baseline to DY2
Breast cancer screening for women	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Breast cancer screening	54.6%	49.7%	-9.0%	44.4%	-10.7%	-18.7%
Molina Healthcare of New Mexico, Inc.						
Breast cancer screening	67.0%	71.4%	6.6%	63.5%	-11.1%	-5.2%
Blue Cross and Blue Shield of New Mexico						
Breast cancer screening	51.4%	51.2%	-0.4%	54.6%	6.5%	6.1%
United Healthcare of New Mexico, Inc.						
Breast cancer screening	44.4%	36.7%	-17.3%	38.9%	6.0%	-12.4%
Total						
Breast cancer screening	54.5%	52.5%	-3.7%	50.7%	-3.3%	-6.9%

Cervical Cancer Screening for Women (Measure 24)[174]

	Baseline	DY1		DY2		Baseline to DY2
Cervical cancer screening for women	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Cervical cancer screening	65.0%	57.3%	-12.0%	56.4%	-1.5%	-13.3%
Molina Healthcare of New Mexico, Inc.						
Cervical cancer screening	66.7%	45.8%	-31.3%	52.7%	15.1%	-20.9%
Blue Cross and Blue Shield of New Mexico						
Cervical cancer screening	48.0%	28.4%	-41.0%	45.8%	61.5%	-4.7%
United Healthcare of New Mexico, Inc.						
Cervical cancer screening	43.1%	27.3%	-36.7%	39.7%	45.5%	-7.9%
Total						
Cervical cancer screening	58.4%	43.2%	-26.0%	48.7%	12.7%	-16.6%

Flu Vaccinations for Adults (Measure 25)

	Baseline	DY1		DY2		DY3		Baseline to DY3
Flu Vaccinations for Adults	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Change (p_3/p_0-1)**
Total								
Flu Vaccinations for Adults	4.5%	5.0%	10.7%	10.3%	106.2%	10.3%	0.2%	128.7%

[173] DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.
[174] DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Measure 26)

	DY1	DY2	
Initiation and engagement of alcohol and other drug dependence treatment	**Rate, p_1**	**Rate, p_2**	**Change (p_2/p_1-1)**
Initiation of AOD Treatment (13-17 Yrs)	36.6%	46.1%	25.9%
Initiation of AOD Treatment (18+ Yrs)	36.7%	39.6%	8.0%
Initiation of AOD Treatment (Total)	36.7%	40.2%	9.7%
Engagement of AOD Treatment (13-17 Yrs)	15.0%	21.5%	43.2%
Engagement of AOD Treatment (18+ Yrs)	14.0%	14.7%	5.0%
Engagement of AOD Treatment (Total)	14.1%	15.3%	8.5%
Molina Healthcare of New Mexico, Inc.			
Initiation of AOD Treatment (13-17 Yrs)	46.6%	44.8%	-3.9%
Initiation of AOD Treatment (18+ Yrs)	38.9%	34.9%	-10.2%
Initiation of AOD Treatment (Total)	39.5%	35.6%	-9.9%
Engagement of AOD Treatment (13-17 Yrs)	17.6%	16.8%	-4.6%
Engagement of AOD Treatment (18+ Yrs)	13.1%	11.7%	-10.7%
Engagement of AOD Treatment (Total)	13.5%	12.0%	-10.5%
Blue Cross and Blue Shield of New Mexico			
Initiation of AOD Treatment (13-17 Yrs)	51.6%	46.6%	-9.7%
Initiation of AOD Treatment (18+ Yrs)	39.0%	37.0%	-4.9%
Initiation of AOD Treatment (Total)	39.5%	37.3%	-5.4%
Engagement of AOD Treatment (13-17 Yrs)	25.0%	16.2%	-35.3%
Engagement of AOD Treatment (18+ Yrs)	14.2%	14.2%	0.0%
Engagement of AOD Treatment (Total)	14.7%	14.3%	-2.4%
United Healthcare of New Mexico, Inc.			
Initiation of AOD Treatment (13-17 Yrs)	NR	NR	N/A
Initiation of AOD Treatment (18+ Yrs)	NR	NR	N/A
Initiation of AOD Treatment (Total)	NR	NR	N/A
Engagement of AOD Treatment (13-17 Yrs)	NR	NR	N/A
Engagement of AOD Treatment (18+ Yrs)	NR	NR	N/A
Engagement of AOD Treatment (Total)	NR	NR	N/A
Total			
Initiation of AOD Treatment (13-17 Yrs)	42.3%	45.6%	7.7%
Initiation of AOD Treatment (18+ Yrs)	38.2%	37.1%	-2.9%
Initiation of AOD Treatment (Total)	38.6%	37.7%	-2.4%
Engagement of AOD Treatment (13-17 Yrs)	17.2%	18.9%	9.8%
Engagement of AOD Treatment (18+ Yrs)	13.7%	13.5%	-1.6%
Engagement of AOD Treatment (Total)	14.0%	13.8%	-1.2%

Annual Monitoring Persistent Medications (Measure 38)[175]

	Baseline	DY1		DY2		Baseline to DY2
Annual monitoring for patients on persistent medications	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Annual monitoring for patients on ACE Inhibitors or ARBs	84.7%	83.9%	-0.9%	83.5%	-0.5%	-1.4%
Annual monitoring for patients on persistent Digoxin	NR	NR	N/A	NR	N/A	N/A
Annual monitoring for patients on Diuretics	87.8%	84.8%	-3.4%	85.8%	1.2%	-2.3%
Annual monitoring for patients: Total	85.9%	84.0%	-2.2%	84.1%	0.1%	-2.1%
Molina Healthcare of New Mexico, Inc.						
Annual monitoring for patients on ACE Inhibitors or ARBs	87.2%	83.1%	-4.7%	82.7%	-0.6%	-5.2%
Annual monitoring for patients on persistent Digoxin	NR	60.0%	N/A	42.9%	-28.6%	N/A
Annual monitoring for patients on Diuretics	88.9%	83.2%	-6.4%	83.5%	0.3%	-6.1%
Annual monitoring for patients: Total	87.8%	83.1%	-5.4%	82.8%	-0.3%	-5.7%
Blue Cross and Blue Shield of New Mexico						
Annual monitoring for patients on ACE Inhibitors or ARBs	89.7%	85.1%	-5.2%	82.7%	-2.8%	-7.8%
Annual monitoring for patients on persistent Digoxin	NR	NR	N/A	NR	N/A	N/A
Annual monitoring for patients on Diuretics	89.8%	85.2%	-5.1%	83.3%	-2.2%	-7.2%
Annual monitoring for patients: Total	89.6%	85.0%	-5.2%	82.8%	-2.5%	-7.6%
United Healthcare of New Mexico, Inc.						
Annual monitoring for patients on ACE Inhibitors or ARBs	88.6%	84.7%	-4.4%	83.0%	-1.9%	-6.3%
Annual monitoring for patients on persistent Digoxin	NR	NR	N/A	NR	N/A	N/A
Annual monitoring for patients on Diuretics	91.5%	86.4%	-5.5%	84.9%	-1.8%	-7.2%
Annual monitoring for patients: Total	89.9%	85.3%	-5.1%	83.5%	-2.1%	-7.1%
Total						
Annual monitoring for patients on ACE Inhibitors or ARBs	86.6%	83.9%	-3.0%	82.9%	-1.2%	-4.2%
Annual monitoring for patients on persistent Digoxin	85.4%	54.3%	-36.4%	42.0%	-22.8%	-50.9%
Annual monitoring for patients on Diuretics	89.0%	84.5%	-5.1%	84.3%	-0.2%	-5.3%
Annual monitoring for patients: Total	87.5%	84.0%	-4.0%	83.3%	-0.9%	-4.9%

[175] All MCOs Digoxin subcomponent numerators and denominators were included in the calculation of aggregate rates in each year; "NR" is shown since the denominators were less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Medication Management for People with Asthma (Measure 39)[176]

	Baseline	DY1		DY2		Baseline to DY2
Medication Management for People With Asthma	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
5-11 Years - Medication Compliance 50%	47.9%	45.5%	-5.0%	53.4%	17.4%	11.5%
12-18 Years - Medication Compliance 50%	42.7%	40.6%	-4.9%	48.9%	20.4%	14.5%
19-50 Years - Medication Compliance 50%	47.4%	51.2%	8.1%	59.8%	16.8%	26.3%
51-64 Years - Medication Compliance 50%	71.4%	56.8%	-20.5%	72.5%	27.7%	1.5%
Total - Medication Compliance 50%	46.4%	44.7%	-3.6%	54.6%	22.0%	17.6%
Molina Healthcare of New Mexico, Inc.						
5-11 Years - Medication Compliance 50%	44.1%	46.2%	4.8%	46.2%	0.0%	4.8%
12-18 Years - Medication Compliance 50%	42.7%	44.2%	3.7%	41.5%	-6.1%	-2.7%
19-50 Years - Medication Compliance 50%	48.5%	47.9%	-1.3%	56.2%	17.3%	15.8%
51-64 Years - Medication Compliance 50%	NR	56.6%	N/A	71.0%	25.6%	N/A
Total - Medication Compliance 50%	44.8%	47.0%	5.0%	49.4%	5.0%	10.3%
Blue Cross and Blue Shield of New Mexico						
5-11 Years - Medication Compliance 50%	43.6%	43.9%	0.6%	45.1%	2.8%	3.5%
12-18 Years - Medication Compliance 50%	43.3%	48.2%	11.3%	35.8%	-25.8%	-17.5%
19-50 Years - Medication Compliance 50%	62.5%	55.3%	-11.6%	59.6%	7.8%	-4.7%
51-64 Years - Medication Compliance 50%	NR	NR	N/A	66.7%	N/A	N/A
Total - Medication Compliance 50%	48.5%	49.5%	2.1%	51.1%	3.2%	5.3%
United Healthcare of New Mexico, Inc.						
5-11 Years - Medication Compliance 50%	NR	NR	N/A	31.6%	N/A	N/A
12-18 Years - Medication Compliance 50%	NR	NR	N/A	36.7%	N/A	N/A
19-50 Years - Medication Compliance 50%	NR	NR	N/A	56.7%	N/A	N/A
51-64 Years - Medication Compliance 50%	NR	63.3%	N/A	67.7%	6.9%	N/A
Total - Medication Compliance 50%	64.9%	67.2%	3.7%	56.3%	-16.3%	-13.2%
Total						
5-11 Years - Medication Compliance 50%	46.5%	45.6%	-2.0%	49.1%	7.7%	5.6%
12-18 Years - Medication Compliance 50%	42.7%	42.2%	-1.1%	44.1%	4.4%	3.2%
19-50 Years - Medication Compliance 50%	50.0%	51.0%	2.0%	58.2%	14.1%	16.3%
51-64 Years - Medication Compliance 50%	69.7%	59.4%	-14.7%	69.6%	17.2%	0.0%
Total - Medication Compliance 50%	46.3%	46.3%	-0.1%	52.2%	12.8%	12.7%

[176] BCBS and UHC baseline and DY1 numerators and denominators (except for UHCs 5-11 years of age cohort) were included in the calculation of aggregate rates in each year; "NR" is shown since the denominators were less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Asthma Medication Ratio (Measure 40)[177]

	Baseline	DY1		DY2		Baseline to DY2
Asthma Medication Ratio	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Asthma Medication Ratio (5-11)	71.7%	62.3%	-13.1%	67.3%	8.1%	-6.1%
Asthma Medication Ratio (12-18)	54.0%	47.7%	-11.6%	50.9%	6.7%	-5.7%
Asthma Medication Ratio (19-50)	36.4%	34.1%	-6.2%	43.6%	27.8%	19.9%
Asthma Medication Ratio (51-64)	34.5%	34.8%	0.9%	50.6%	45.4%	46.6%
Asthma Medication Ratio: Total	59.3%	51.5%	-13.2%	54.2%	5.2%	-8.6%
Molina Healthcare of New Mexico, Inc.						
Asthma Medication Ratio (5-11)	69.2%	60.9%	-12.0%	74.7%	22.5%	7.9%
Asthma Medication Ratio (12-18)	58.5%	51.7%	-11.7%	57.1%	10.5%	-2.4%
Asthma Medication Ratio (19-50)	43.6%	44.4%	1.8%	49.9%	12.4%	14.5%
Asthma Medication Ratio (51-64)	31.0%	49.6%	60.4%	51.4%	3.6%	66.2%
Asthma Medication Ratio: Total	60.1%	53.0%	-11.8%	61.2%	15.5%	1.8%
Blue Cross and Blue Shield of New Mexico						
Asthma Medication Ratio (5-11)	85.6%	62.5%	-27.0%	66.3%	6.1%	-22.5%
Asthma Medication Ratio (12-18)	65.2%	47.0%	-28.0%	53.6%	14.1%	-17.8%
Asthma Medication Ratio (19-50)	70.2%	55.6%	-20.9%	50.1%	-9.8%	-28.6%
Asthma Medication Ratio (51-64)	NR	NR	N/A	60.5%	N/A	N/A
Asthma Medication Ratio: Total	74.8%	55.0%	-26.4%	56.8%	3.3%	-24.0%
United Healthcare of New Mexico, Inc.						
Asthma Medication Ratio (5-11)	NR	NR	N/A	70.0%	N/A	N/A
Asthma Medication Ratio (12-18)	NR	NR	N/A	55.9%	N/A	N/A
Asthma Medication Ratio (19-50)	36.7%	46.7%	27.3%	42.4%	-9.2%	15.6%
Asthma Medication Ratio (51-64)	42.4%	51.2%	20.7%	48.2%	-6.0%	13.5%
Asthma Medication Ratio: Total	40.0%	49.4%	23.6%	47.7%	-3.5%	19.2%
Total						
Asthma Medication Ratio (5-11)	71.9%	61.9%	-13.9%	70.2%	13.5%	-2.3%
Asthma Medication Ratio (12-18)	55.9%	48.9%	-12.5%	53.8%	9.9%	-3.8%
Asthma Medication Ratio (19-50)	41.8%	40.6%	-3.0%	46.8%	15.4%	11.9%
Asthma Medication Ratio (51-64)	36.6%	45.6%	24.6%	52.4%	14.8%	43.0%
Asthma Medication Ratio: Total	60.2%	52.2%	-13.3%	56.8%	8.7%	-5.7%

[177] BCBS and UHC baseline and DY1 numerators and denominators (except for UHCs 5-11 years of age cohort) were included in the calculation of aggregate rates in each year; "NR" is shown since the denominators were less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Adult BMI Assessment and Weight Assessment for Children/Adolescents (Measure 41)[178]

	Baseline	DY1		DY2		Baseline to DY2
Adult Body Mass Index (BMI) assessment; weight assessment for children/adolescents	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Adult BMI assessment	73.4%	84.3%	14.9%	83.9%	-0.5%	14.4%
BMI Percentile (3-11 Yrs)	34.6%	44.7%	29.3%	61.7%	38.0%	78.5%
BMI Percentile (12-17 Yrs)	40.6%	40.8%	0.3%	64.8%	59.0%	59.6%
BMI Percentile (Total)	36.8%	43.3%	17.5%	62.8%	45.1%	70.5%
Counseling for Nutrition (3-11 Yrs)	48.9%	55.7%	13.9%	51.8%	-6.9%	6.0%
Counseling for Nutrition (12-17 Yrs)	43.1%	47.8%	10.8%	50.3%	5.4%	16.7%
Counseling for Nutrition (Total)	46.8%	52.8%	12.9%	51.3%	-2.8%	9.7%
Counseling for Physical Activity (3-11 Yrs)	38.2%	44.7%	16.9%	37.2%	-16.7%	-2.6%
Counseling for Physical Activity (12-17 Yrs)	40.0%	42.0%	5.1%	51.7%	23.0%	29.3%
Counseling for Physical Activity (Total)	38.9%	43.7%	12.4%	42.2%	-3.4%	8.6%
Molina Healthcare of New Mexico, Inc.						
Adult BMI assessment	81.0%	74.5%	-8.1%	79.7%	7.0%	-1.7%
BMI Percentile (3-11 Yrs)	57.8%	32.3%	-44.1%	53.7%	66.1%	-7.2%
BMI Percentile (12-17 Yrs)	56.4%	40.0%	-29.1%	51.6%	29.1%	-8.5%
BMI Percentile (Total)	57.4%	35.0%	-39.1%	53.0%	51.6%	-7.7%
Counseling for Nutrition (3-11 Yrs)	51.1%	55.2%	8.0%	54.0%	-2.2%	5.7%
Counseling for Nutrition (12-17 Yrs)	49.3%	49.7%	0.8%	50.3%	1.3%	2.1%
Counseling for Nutrition (Total)	50.6%	53.3%	5.5%	52.8%	-1.0%	4.4%
Counseling for Physical Activity (3-11 Yrs)	41.5%	50.2%	20.8%	49.3%	-1.7%	18.8%
Counseling for Physical Activity (12-17 Yrs)	45.7%	47.7%	4.4%	49.7%	4.0%	8.7%
Counseling for Physical Activity (Total)	42.8%	49.3%	15.2%	49.4%	0.2%	15.5%
Blue Cross and Blue Shield of New Mexico						
Adult BMI assessment	71.7%	79.2%	10.6%	72.1%	-9.0%	0.6%
BMI Percentile (3-11 Yrs)	52.9%	55.2%	4.3%	52.7%	-4.5%	-0.4%
BMI Percentile (12-17 Yrs)	46.2%	55.8%	20.9%	53.2%	-4.7%	15.2%
BMI Percentile (Total)	51.0%	55.4%	8.7%	52.9%	-4.6%	3.7%
Counseling for Nutrition (3-11 Yrs)	41.5%	57.1%	37.7%	43.4%	-24.0%	4.6%
Counseling for Nutrition (12-17 Yrs)	36.2%	52.2%	44.3%	41.8%	-19.8%	15.7%
Counseling for Nutrition (Total)	40.0%	55.6%	39.2%	42.9%	-22.8%	7.4%
Counseling for Physical Activity (3-11 Yrs)	34.4%	48.9%	42.3%	38.6%	-21.1%	12.3%
Counseling for Physical Activity (12-17 Yrs)	37.7%	52.9%	40.3%	40.4%	-23.6%	7.3%
Counseling for Physical Activity (Total)	35.3%	50.1%	41.9%	39.2%	-21.9%	10.9%
United Healthcare of New Mexico, Inc.						
Adult BMI assessment	71.5%	74.5%	4.1%	71.7%	-3.8%	0.2%
BMI Percentile (3-11 Yrs)	NR	43.8%	N/A	48.1%	9.9%	N/A
BMI Percentile (12-17 Yrs)	NR	43.8%	N/A	42.6%	-2.7%	N/A
BMI Percentile (Total)	NR	43.8%	N/A	46.2%	5.6%	N/A
Counseling for Nutrition (3-11 Yrs)	NR	53.4%	N/A	54.8%	2.7%	N/A
Counseling for Nutrition (12-17 Yrs)	NR	43.1%	N/A	52.5%	21.7%	N/A
Counseling for Nutrition (Total)	NR	49.4%	N/A	54.0%	9.4%	N/A
Counseling for Physical Activity (3-11 Yrs)	NR	31.5%	N/A	43.3%	37.7%	N/A
Counseling for Physical Activity (12-17 Yrs)	NR	40.6%	N/A	50.4%	23.9%	N/A
Counseling for Physical Activity (Total)	NR	35.0%	N/A	45.7%	30.6%	N/A
Total						
Adult BMI assessment	74.2%	78.2%	5.4%	76.0%	-2.8%	2.4%
BMI Percentile (3-11 Yrs)	49.2%	44.2%	-10.1%	54.0%	22.3%	9.9%
BMI Percentile (12-17 Yrs)	47.4%	44.8%	-5.5%	53.1%	18.7%	12.1%
BMI Percentile (Total)	48.6%	44.4%	-8.7%	53.7%	21.0%	10.5%
Counseling for Nutrition (3-11 Yrs)	47.4%	55.5%	16.9%	50.8%	-8.4%	7.1%
Counseling for Nutrition (12-17 Yrs)	43.5%	48.0%	10.4%	48.8%	1.6%	12.1%
Counseling for Nutrition (Total)	46.2%	52.9%	14.5%	50.1%	-5.1%	8.6%
Counseling for Physical Activity (3-11 Yrs)	38.3%	44.4%	15.9%	42.2%	-5.0%	10.1%
Counseling for Physical Activity (12-17 Yrs)	41.2%	45.6%	10.5%	48.1%	5.6%	16.7%
Counseling for Physical Activity (Total)	39.2%	44.8%	14.2%	44.1%	-1.4%	12.5%

[178] UHC baseline numerators and denominators were included in the calculation of aggregate rates; "NR" is shown since the denominators were less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Annual Rate Data for Diabetes - annual recommended tests (A1C, LDL, eye exam, nephropathy exam (Measure 42 & 81)[179]

	Baseline	DY1		DY2		Baseline to DY2
Diabetes - annual recommended tests (A1C, LDL, eye exam, nephropathy exam)	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
HbA1c Testing	81.4%	86.5%	6.3%	84.6%	-2.2%	3.9%
HbA1c Poor Control (>9.0%)	47.9%	43.9%	-8.3%	48.3%	10.1%	0.9%
HbA1c Control (<8.0%)	42.8%	47.9%	12.0%	44.9%	-6.4%	4.8%
HbA1c Control (<7.0%) for a Selected Population	33.3%	35.2%	5.7%	31.9%	-9.5%	-4.4%
Eye Exam	48.3%	47.8%	-1.0%	46.1%	-3.5%	-4.5%
Medical Attention for Nephropathy	71.6%	79.5%	11.0%	86.9%	9.3%	21.3%
Blood Pressure Controlled <140/90 mm Hg	63.7%	64.2%	0.9%	62.7%	-2.5%	-1.6%
Molina Healthcare of New Mexico, Inc.						
HbA1c Testing	85.1%	85.7%	0.6%	88.1%	2.8%	3.5%
HbA1c Poor Control (>9.0%)	41.8%	49.9%	19.5%	45.0%	-9.7%	7.8%
HbA1c Control (<8.0%)	48.5%	37.7%	-22.2%	45.0%	19.3%	-7.2%
HbA1c Control (<7.0%) for a Selected Population	NR	NR	N/A	NR	N/A	N/A
Eye Exam	58.2%	56.5%	-3.0%	54.5%	-3.5%	-6.4%
Medical Attention for Nephropathy	78.1%	74.8%	-4.2%	88.1%	17.7%	12.8%
Blood Pressure Controlled <140/90 mm Hg	64.3%	59.4%	-7.7%	62.0%	4.5%	-3.6%
Blue Cross and Blue Shield of New Mexico						
HbA1c Testing	82.2%	83.4%	1.4%	80.4%	-3.6%	-2.2%
HbA1c Poor Control (>9.0%)	53.6%	47.3%	-11.7%	52.9%	11.9%	-1.2%
HbA1c Control (<8.0%)	36.3%	43.1%	18.7%	39.3%	-8.8%	8.2%
HbA1c Control (<7.0%) for a Selected Population	NR	NR	N/A	NR	N/A	N/A
Eye Exam	51.9%	54.2%	4.5%	47.8%	-11.9%	-8.0%
Medical Attention for Nephropathy	75.4%	78.6%	4.2%	85.1%	8.2%	12.8%
Blood Pressure Controlled <140/90 mm Hg	55.7%	57.4%	2.9%	55.9%	-2.6%	0.3%
United Healthcare of New Mexico, Inc.						
HbA1c Testing	85.9%	84.4%	-1.7%	84.4%	0.0%	-1.7%
HbA1c Poor Control (>9.0%)	49.5%	49.1%	-0.8%	52.6%	6.9%	6.1%
HbA1c Control (<8.0%)	41.9%	43.3%	3.4%	37.5%	-13.5%	-10.6%
HbA1c Control (<7.0%) for a Selected Population	NR	NR	N/A	NR	N/A	N/A
Eye Exam	44.0%	65.2%	48.3%	62.5%	-4.1%	42.2%
Medical Attention for Nephropathy	82.9%	83.7%	1.0%	90.3%	7.8%	8.9%
Blood Pressure Controlled <140/90 mm Hg	62.5%	54.7%	-12.4%	52.3%	-4.4%	-16.3%
Total						
HbA1c Testing	83.5%	85.0%	1.8%	84.1%	-1.0%	0.7%
HbA1c Poor Control (>9.0%)	47.9%	47.2%	-1.5%	49.8%	5.4%	3.9%
HbA1c Control (<8.0%)	42.7%	43.4%	1.6%	41.8%	-3.7%	-2.1%
HbA1c Control (<7.0%) for a Selected Population	33.3%	35.2%	5.7%	31.9%	-9.5%	-4.4%
Eye Exam	50.4%	55.0%	9.2%	51.8%	-5.9%	2.7%
Medical Attention for Nephropathy	76.6%	79.1%	3.3%	87.3%	10.4%	14.0%
Blood Pressure Controlled <140/90 mm Hg	62.0%	59.3%	-4.4%	58.4%	-1.4%	-5.7%

[179] DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Antidepressant Medication Management (Measure 50)

Antidepressant medication management	Baseline	DY1		DY2		Baseline to DY2
	Rate, p_0	Rate, p_1	Change (p_1/p_0-1)	Rate, p_2	Change (p_2/p_1-1)	Change (p_2/p_0-1)
Presbyterian Health Plan						
Effective Acute Phase Treatment	NR	53.9%	N/A	53.4%	-1.1%	N/A
Effective Continuation Phase Treatment	NR	39.0%	N/A	36.2%	-7.0%	N/A
Molina Healthcare of New Mexico, Inc.						
Effective Acute Phase Treatment	40.8%	53.5%	31.2%	49.5%	-7.4%	21.5%
Effective Continuation Phase Treatment	25.1%	38.6%	54.2%	34.7%	-10.2%	38.4%
Blue Cross and Blue Shield of New Mexico						
Effective Acute Phase Treatment	42.8%	60.0%	40.2%	54.8%	-8.6%	28.1%
Effective Continuation Phase Treatment	29.9%	47.8%	59.8%	39.4%	-17.5%	31.8%
United Healthcare of New Mexico, Inc.						
Effective Acute Phase Treatment	51.0%	62.5%	22.6%	56.6%	-9.4%	11.0%
Effective Continuation Phase Treatment	37.1%	48.3%	30.4%	42.9%	-11.3%	15.7%
Total						
Effective Acute Phase Treatment	43.2%	55.6%	28.6%	53.1%	-4.4%	22.9%
Effective Continuation Phase Treatment	28.6%	41.1%	43.9%	37.8%	-8.1%	32.2%

Percentage of the Population Accessing a Behavioral Health Service that Received a PCP Visit in the Same Year (Measure 54)

Percentage of population accessing a behavioral health service that received a PCP visit in the same year	Baseline	DY1		DY2		Baseline to DY2
	Rate, p_0	Rate, p_1	Change (p_1/p_0-1)	Rate, p_2	Change (p_2/p_1-1)	Change (p_2/p_0-1)
Total						
Percentage of population accessing a behavioral health service that received a PCP visit in the same year	13.6%	12.6%	-7.6%	12.2%	-3.2%	-10.6%

Percentage of the Population Accessing an LTSS Service that Received a PCP Visit in the Same Year (Measure 55)

Percentage of LTSS population accessing a PCP visit during the year	Baseline	DY1		DY2		DY3		Baseline to DY3
	Rate, p_0	Rate, p_1	Change (p_1/p_0-1)	Rate, p_2	Change (p_2/p_1-1)	Rate, p_3	Change (p_3/p_2-1)	Change (p_3/p_0-1)
Total								
Percentage of LTSS population accessing a PCP visit during the year	76.5%	73.5%	-3.8%	70.7%	-3.8%	69.4%	-1.9%	-9.3%

Percentage of the Population Accessing an LTSS Service that also accessed a BH Service in the Same Year (Measure 56)

Percentage of population accessing an LTSS service that also accessed a BH service in the same year	Baseline	DY1		DY2		DY3		Baseline to DY3
	Rate, p_0	Rate, p_1	Change (p_1/p_0-1)	Rate, p_2	Change (p_2/p_1-1)	Rate, p_3	Change (p_3/p_2-1)	Change (p_2/p_0-1)
Total								
Percentage of population accessing an LTSS service that also accessed a BH service in the same year	1.12%	1.06%	-5.38%	1.32%	25.14%	1.39%	4.89%	24.20%

Percentage of the Population with LTSS Needs with an ED Visit by Type of ED Visit (Measure 57)

	Baseline	DY1		DY2		Baseline to DY2
Percentage of population with BH needs with an ED visit by type of ED visit	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Total						
BH Population with ER Visits	18.7%	11.0%	-41.0%	7.0%	-36.49%	-62.51%
BH Population with EMTALA ER Visit Type	0.2%	0.1%	-58.9%	0.1%	-13.01%	-64.27%
BH Population with Urgent Care ER Visit Type	0.0%	0.0%	-100.0%	0.0%	N/A	-95.53%
BH Population with Limited or Minor ER Visit Type	0.6%	0.3%	-45.2%	0.4%	15.09%	-36.91%
BH Population with Low to Moderate ER Visit Type	1.8%	0.6%	-66.7%	0.7%	23.54%	-58.85%
BH Population with Moderate ER Visit Type	6.4%	2.5%	-61.2%	2.2%	-11.30%	-65.59%
BH Population with High Severity ER Visit Type	7.0%	2.2%	-68.0%	2.5%	12.59%	-63.96%
BH Population with Life Threatening ER Visit Type	5.4%	2.5%	-54.1%	2.3%	-7.48%	-57.55%
BH Population with Admitted Through ER Visit Type	3.6%	5.1%	44.1%	0.9%	-82.76%	-75.16%

Percentage of the Population with BH Needs with an ED Visit by Type of ED Visit (Measure 58)

	Baseline	DY1		DY2		Baseline to DY2
Percentage of population with LTSS needs with an ED visit by type of ED visit	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Total						
BH Population with ER Visits	35.71%	37.56%	5.18%	44.22%	17.71%	23.82%
BH Population with EMTALA ER Visit Type	0.30%	0.25%	-14.62%	0.29%	14.99%	-1.82%
BH Population with Urgent Care ER Visit Type	0.02%	0.02%	-15.91%	0.01%	-32.54%	-43.27%
BH Population with Limited or Minor ER Visit Type	1.50%	1.76%	16.96%	2.68%	52.12%	77.92%
BH Population with Low to Moderate ER Visit Type	3.91%	3.73%	-4.59%	4.88%	30.78%	24.78%
BH Population with Moderate ER Visit Type	13.33%	13.78%	3.38%	16.06%	16.60%	20.53%
BH Population with High Severity ER Visit Type	15.18%	15.46%	1.84%	19.67%	27.28%	29.61%
BH Population with Life Threatening ER Visit Type	13.19%	14.07%	6.68%	17.22%	22.39%	30.57%
BH Population with Admitted Through ER Visit Type	8.66%	12.78%	47.62%	14.47%	13.16%	67.05%

Percentage of Participants Who Accessed a BH Service that also Accessed HCBS (Measure 60)

	Baseline	DY1		DY2		Baseline to DY3
Number and percentage of participants who accessed a BH service that also accessed HCBS	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Total						
Number and percentage of participants who accessed a BH service that also accessed HCBS	0.19%	0.21%	13.21%	0.23%	10.22%	15.37%

Percentage of the Population Accessing a BH Service that Received an Outpatient Ambulatory Visit in the Same Year (Measure 62)

	Baseline	DY1		DY2		Baseline to DY2
Percentage of population accessing a BH service that received an outpatient ambulatory visit in the same year	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Total						
Percentage of population accessing a BH service that received an outpatient ambulatory visit in the same year	14.5%	13.9%	-4.4%	15.6%	12.7%	7.7%

Diabetes Screening for Members with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (Measure 63)[180]

	Baseline	DY1		DY2		Baseline to DY2
Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	85.3%	79.8%	-6.4%	79.7%	-0.1%	-6.6%
Molina Healthcare of New Mexico, Inc.						
Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	79.5%	77.0%	-3.2%	78.5%	1.9%	-1.3%
Blue Cross and Blue Shield of New Mexico						
Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	NR	79.7%	N/A	76.3%	-4.2%	N/A
United Healthcare of New Mexico, Inc.						
Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	80.7%	74.2%	-8.0%	76.5%	3.0%	-5.2%
Total						
Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	83.7%	77.6%	-7.2%	77.9%	0.3%	-7.0%

[180] BCBS baseline numerator and denominator were included in the calculation of aggregate rates; "NR" is shown since the denominator was less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Diabetes Monitoring for People with Diabetes and Schizophrenia (Measure 64)[181]

	Baseline	DY1		DY2		Baseline to DY2
Diabetes monitoring for people with diabetes and schizophrenia	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Diabetes monitoring for people with diabetes and schizophrenia	76.7%	75.0%	-2.2%	54.9%	-26.8%	-28.4%
Molina Healthcare of New Mexico, Inc.						
Diabetes monitoring for people with diabetes and schizophrenia	NR	57.9%	N/A	55.0%	-4.9%	N/A
Blue Cross and Blue Shield of New Mexico						
Diabetes monitoring for people with diabetes and schizophrenia	NR	44.6%	N/A	44.9%	0.7%	N/A
United Healthcare of New Mexico, Inc.						
Diabetes monitoring for people with diabetes and schizophrenia	55.8%	49.8%	-10.9%	47.4%	-4.7%	-15.0%
Total						
Diabetes monitoring for people with diabetes and schizophrenia	62.4%	56.6%	-9.2%	49.9%	-11.8%	-20.0%

[181] MHC and BCBS baseline numerators and denominators were included in the calculation of aggregate rates; "NR" is shown since the denominators were less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Statistical Significance Testing of Annual Rate Data for Asthma controller medication compliance (Measure 80)[182]

	Baseline	DY1		DY2		Baseline to DY2
Asthma controller medication compliance (children)	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Medication Compliance - 50% (5-11)	47.9%	45.5%	-5.0%	53.4%	17.4%	11.5%
Medication Compliance - 75% (5-11)	20.9%	21.3%	2.0%	26.5%	24.1%	26.6%
Medication Compliance - 50% (12-18)	42.7%	40.6%	-4.9%	48.9%	20.4%	14.5%
Medication Compliance - 75% (12-18)	19.5%	18.9%	-3.4%	25.4%	34.8%	30.2%
Molina Healthcare of New Mexico, Inc.						
Medication Compliance - 50% (5-11)	44.1%	46.2%	4.8%	46.2%	0.0%	4.8%
Medication Compliance - 75% (5-11)	22.2%	23.1%	4.2%	21.7%	-6.0%	-2.1%
Medication Compliance - 50% (12-18)	42.7%	44.2%	3.7%	41.5%	-6.1%	-2.7%
Medication Compliance - 75% (12-18)	18.8%	19.1%	2.0%	18.9%	-1.2%	0.7%
Blue Cross and Blue Shield of New Mexico						
Medication Compliance - 50% (5-11)	43.6%	43.9%	0.6%	45.1%	2.8%	3.5%
Medication Compliance - 75% (5-11)	18.1%	20.4%	12.8%	22.0%	7.6%	21.4%
Medication Compliance - 50% (12-18)	43.3%	48.2%	11.3%	35.8%	-25.8%	-17.5%
Medication Compliance - 75% (12-18)	16.7%	25.0%	50.0%	15.1%	-39.7%	-9.5%
United Healthcare of New Mexico, Inc.						
Medication Compliance - 50% (5-11)	NR	NR	N/A	31.6%	N/A	N/A
Medication Compliance - 75% (5-11)	NR	NR	N/A	NR	N/A	N/A
Medication Compliance - 50% (12-18)	NR	NR	N/A	36.7%	N/A	N/A
Medication Compliance - 75% (12-18)	NR	NR	N/A	13.3%	N/A	N/A
Total						
Medication Compliance - 50% (5-11)	46.5%	45.6%	-2.0%	49.1%	7.7%	5.6%
Medication Compliance - 75% (5-11)	21.1%	21.8%	3.4%	24.3%	11.5%	15.2%
Medication Compliance - 50% (12-18)	42.7%	42.2%	-1.1%	44.1%	4.4%	3.2%
Medication Compliance - 75% (12-18)	19.2%	19.4%	1.0%	21.3%	9.9%	11.0%

[182] UHC baseline and DY1 numerators and denominators for the 12-18 age cohort were included in the calculation of aggregate rates; "NR" is shown since the denominators were less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Prenatal program (Measure 82)[183]

	Baseline	DY1		DY2		Baseline to DY2
Frequency of Prenatal Care	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Frequency of Ongoing Prenatal Care (<21%)	9.3%	13.6%	47.4%	21.3%	56.4%	130.5%
Frequency of Ongoing Prenatal Care (21-40%)	10.6%	12.5%	17.1%	10.9%	-12.6%	2.4%
Frequency of Ongoing Prenatal Care (41-60%)	9.3%	12.7%	37.2%	10.7%	-16.0%	15.3%
Frequency of Ongoing Prenatal Care (61-80%)	13.9%	12.5%	-10.2%	14.2%	13.5%	1.9%
Frequency of Ongoing Prenatal Care (>= 81%)	56.9%	48.7%	-14.5%	42.9%	-11.9%	-24.6%
Molina Healthcare of New Mexico, Inc.						
Frequency of Ongoing Prenatal Care (<21%)	4.0%	9.0%	124.2%	7.6%	-16.2%	87.9%
Frequency of Ongoing Prenatal Care (21-40%)	3.5%	7.7%	115.9%	7.8%	1.6%	119.4%
Frequency of Ongoing Prenatal Care (41-60%)	5.7%	8.3%	46.9%	10.3%	23.6%	81.5%
Frequency of Ongoing Prenatal Care (61-80%)	13.5%	14.0%	3.6%	19.0%	36.0%	40.9%
Frequency of Ongoing Prenatal Care (>= 81%)	73.3%	61.0%	-16.7%	55.4%	-9.3%	-24.4%
Blue Cross and Blue Shield of New Mexico						
Frequency of Ongoing Prenatal Care (<21%)	7.7%	16.1%	107.4%	11.6%	-27.9%	49.6%
Frequency of Ongoing Prenatal Care (21-40%)	6.0%	7.7%	28.8%	10.7%	39.0%	79.0%
Frequency of Ongoing Prenatal Care (41-60%)	9.3%	6.6%	-29.4%	11.1%	69.7%	19.8%
Frequency of Ongoing Prenatal Care (61-80%)	16.2%	14.5%	-10.3%	16.0%	10.7%	-0.7%
Frequency of Ongoing Prenatal Care (>= 81%)	60.8%	55.2%	-9.3%	50.6%	-8.4%	-16.9%
United Healthcare of New Mexico, Inc.						
Frequency of Ongoing Prenatal Care (<21%)	NR	20.7%	N/A	20.4%	-1.2%	N/A
Frequency of Ongoing Prenatal Care (21-40%)	NR	12.2%	N/A	23.1%	90.0%	N/A
Frequency of Ongoing Prenatal Care (41-60%)	NR	11.2%	N/A	10.5%	-6.5%	N/A
Frequency of Ongoing Prenatal Care (61-80%)	NR	13.4%	N/A	11.9%	-10.9%	N/A
Frequency of Ongoing Prenatal Care (>= 81%)	NR	42.6%	N/A	34.1%	-20.0%	N/A
Total						
Frequency of Ongoing Prenatal Care (<21%)	7.4%	14.8%	100.1%	15.1%	2.4%	104.9%
Frequency of Ongoing Prenatal Care (21-40%)	6.8%	9.9%	45.2%	13.0%	30.5%	89.5%
Frequency of Ongoing Prenatal Care (41-60%)	8.1%	9.6%	19.7%	10.6%	10.5%	32.2%
Frequency of Ongoing Prenatal Care (61-80%)	14.5%	13.6%	-6.4%	15.3%	12.9%	5.7%
Frequency of Ongoing Prenatal Care (>= 81%)	63.2%	52.1%	-17.6%	45.9%	-11.8%	-27.3%

	Baseline	DY1		DY2		Baseline to DY2
Prenatal and Postpartum Care	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Postpartum Care	57.9%	61.9%	6.9%	53.1%	-14.1%	-8.2%
Timeliness of Prenatal Care	80.0%	77.9%	-2.7%	66.4%	-14.8%	-17.1%
Molina Healthcare of New Mexico, Inc.						
Postpartum Care	62.9%	54.5%	-13.4%	51.5%	-5.5%	-18.1%
Timeliness of Prenatal Care	89.2%	76.8%	-13.9%	76.0%	-1.1%	-14.8%
Blue Cross and Blue Shield of New Mexico						
Postpartum Care	63.1%	54.5%	-13.5%	57.9%	6.2%	-8.2%
Timeliness of Prenatal Care	86.1%	73.1%	-15.1%	72.6%	-0.6%	-15.6%
United Healthcare of New Mexico, Inc.						
Postpartum Care	NR	48.2%	N/A	41.4%	-14.1%	N/A
Timeliness of Prenatal Care	NR	63.7%	N/A	67.4%	5.7%	N/A
Total						
Postpartum Care	61.3%	54.8%	-10.5%	51.2%	-6.7%	-16.5%
Timeliness of Prenatal Care	84.8%	73.0%	-13.9%	70.7%	-3.2%	-16.6%

[183] UHC baseline numerators and denominators were included in the calculation of aggregate rates; "NR" is shown since the denominators were less than 30.
DY2 Prenatal and Postpartum Care rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Treatment adherence – schizophrenia (Measure 83)[184]

Treatment adherence - schizophrenia	Baseline	DY1		DY2		Baseline to DY2
	Rate, p_0	Rate, p_1	Change (p_1/p_0-1)	Rate, p_2	Change (p_2/p_1-1)	Change (p_2/p_0-1)
Presbyterian Health Plan						
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	24.0%	58.1%	141.9%	56.5%	-2.7%	135.4%
Molina Healthcare of New Mexico, Inc.						
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	NR	58.7%	N/A	52.8%	-10.0%	N/A
Blue Cross and Blue Shield of New Mexico						
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	NR	60.0%	N/A	44.6%	-25.6%	N/A
United Healthcare of New Mexico, Inc.						
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	50.0%	61.1%	22.2%	54.6%	-10.6%	9.2%
Total						
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	34.7%	59.3%	70.8%	52.2%	-12.0%	50.3%

Annual dental visit – adult (Measure 86)

Annual dental visit – adult	Baseline	DY1		DY2		Baseline to DY2
	Rate, p_0	Rate, p_1	Change (p_1/p_0-1)	Rate, p_2	Change (p_2/p_1-1)	Change (p_2/p_0-1)
Presbyterian Health Plan						
Annual Dental Visit (19-21 Yrs)	44.2%	39.3%	-11.1%	41.2%	4.8%	-6.9%
Molina Healthcare of New Mexico, Inc.						
Annual Dental Visit (19-21 Yrs)	45.9%	35.5%	-22.8%	43.6%	22.9%	-5.2%
Blue Cross and Blue Shield of New Mexico						
Annual Dental Visit (19-21 Yrs)	41.0%	29.6%	-27.8%	37.1%	25.2%	-9.7%
United Healthcare of New Mexico, Inc.						
Annual Dental Visit (19-21 Yrs)	NR	25.9%	N/A	28.6%	10.4%	N/A
Total						
Annual Dental Visit (19-21 Yrs)	44.4%	34.9%	-21.5%	40.4%	15.9%	-9.0%

[184] MHC and BCBS baseline numerators and denominators were included in the calculation of aggregate rates; "NR" is shown since the denominators were less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Annual dental visit – child (Measure 87)[185]

	Baseline	DY1		DY2		Baseline to DY2
Annual dental visit – child	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Annual Dental Visit (2-3 Yrs)	55.6%	54.4%	-2.3%	52.9%	-2.6%	-4.8%
Annual Dental Visit (4-6 Yrs)	75.0%	73.2%	-2.5%	71.7%	-2.1%	-4.5%
Annual Dental Visit (7-10 Yrs)	79.1%	76.7%	-3.0%	75.0%	-2.3%	-5.3%
Annual Dental Visit (11-14 Yrs)	74.1%	72.6%	-2.0%	70.6%	-2.8%	-4.8%
Annual Dental Visit (15-18 Yrs)	64.3%	61.9%	-3.7%	61.5%	-0.7%	-4.3%
Molina Healthcare of New Mexico, Inc.						
Annual Dental Visit (2-3 Yrs)	55.6%	51.1%	-8.1%	57.8%	13.2%	4.1%
Annual Dental Visit (4-6 Yrs)	74.3%	67.8%	-8.6%	74.8%	10.2%	0.7%
Annual Dental Visit (7-10 Yrs)	78.9%	71.0%	-10.0%	78.3%	10.2%	-0.8%
Annual Dental Visit (11-14 Yrs)	74.2%	66.2%	-10.9%	74.7%	12.9%	0.6%
Annual Dental Visit (15-18 Yrs)	64.0%	57.1%	-10.9%	65.1%	14.1%	1.7%
Blue Cross and Blue Shield of New Mexico						
Annual Dental Visit (2-3 Yrs)	56.5%	47.8%	-15.4%	48.8%	2.0%	-13.6%
Annual Dental Visit (4-6 Yrs)	73.3%	63.3%	-13.7%	65.2%	3.1%	-11.1%
Annual Dental Visit (7-10 Yrs)	75.5%	66.9%	-11.3%	68.1%	1.7%	-9.8%
Annual Dental Visit (11-14 Yrs)	68.1%	61.4%	-9.9%	63.5%	3.4%	-6.8%
Annual Dental Visit (15-18 Yrs)	59.1%	51.4%	-13.0%	55.2%	7.3%	-6.6%
United Healthcare of New Mexico, Inc.						
Annual Dental Visit (2-3 Yrs)	NR	36.4%	N/A	41.8%	14.6%	N/A
Annual Dental Visit (4-6 Yrs)	NR	51.3%	N/A	58.4%	13.9%	N/A
Annual Dental Visit (7-10 Yrs)	NR	54.8%	N/A	59.2%	8.0%	N/A
Annual Dental Visit (11-14 Yrs)	NR	48.8%	N/A	54.6%	12.0%	N/A
Annual Dental Visit (15-18 Yrs)	NR	39.9%	N/A	42.3%	6.2%	N/A
Total						
Annual Dental Visit (2-3 Yrs)	55.7%	51.6%	-7.5%	53.5%	3.8%	-4.0%
Annual Dental Visit (4-6 Yrs)	74.6%	69.3%	-7.1%	71.1%	2.7%	-4.7%
Annual Dental Visit (7-10 Yrs)	78.7%	72.9%	-7.4%	74.6%	2.3%	-5.2%
Annual Dental Visit (11-14 Yrs)	73.6%	68.4%	-7.1%	70.4%	3.0%	-4.3%
Annual Dental Visit (15-18 Yrs)	63.8%	58.5%	-8.3%	61.0%	4.4%	-4.3%

Calls answered within 30 seconds (Measure 93)

	Baseline	DY1		DY2		Baseline to DY2
Calls answered within 30 seconds	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Call Answer Timeliness	86.8%	87.8%	1.1%	88.0%	0.3%	1.4%
Molina Healthcare of New Mexico, Inc.						
Call Answer Timeliness	95.6%	93.7%	-2.0%	NR	N/A	N/A
Blue Cross and Blue Shield of New Mexico						
Call Answer Timeliness	NR	89.7%	N/A	NR	N/A	N/A
United Healthcare of New Mexico, Inc.						
Call Answer Timeliness	93.4%	92.9%	-0.5%	95.2%	2.4%	1.9%
Total						
Call Answer Timeliness	90.6%	90.7%	0.1%	90.4%	-0.3%	-0.2%

[185] UHC baseline numerators and denominators for the 11-14 and 15-18 age cohorts were included in the calculation of aggregate rates; "NR" is shown since the denominators were less than 30.

D. Additional DY3 Data for HEDIS Measures

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

Measure Number and Name		Description (as applicable)	2013 Baseline Value	DY1 Value	DY2 Value	DY3 Value
1	Access to preventive/ambulatory health services among CC enrollees in aggregate and within subgroups		85.5%	81.4%	78.1%	76.0%
2	Mental Health Services Utilization		N/A	13.9%	13.7%	14.0%
6	Number and percentage of people with annual dental visit		111,798 (70.6%)	148,066 (64.0%)	171,663 (66.0%)	184,458 (67.6%)
17	Childhood Immunization Status	DTaP	80.4%	80.2%	67.9%	74.1%
		IPV	90.9%	90.5%	80.6%	86.0%
		MMR	90.5%	91.1%	83.0%	87.0%
		HiB	91.5%	91.3%	80.5%	85.3%
		Hepatitis B	87.6%	88.4%	79.5%	84.3%
		VZV	91.0%	90.6%	82.6%	86.6%
		PCV	80.2%	79.8%	68.3%	75.2%
		Hepatitis A	87.1%	87.9%	81.2%	85.0%
		Rotavirus	73.3%	75.0%	64.5%	71.2%
		Influenza	54.5%	52.7%	45.6%	45.3%
		Combo 2	74.9%	75.0%	64.0%	69.4%
		Combo 3	71.1%	71.7%	60.9%	66.7%
		Combo 4	68.7%	69.4%	59.3%	65.4%
		Combo 5	59.9%	61.6%	52.7%	59.0%
		Combo 6	45.5%	44.5%	38.0%	38.4%
		Combo 7	58.4%	59.9%	51.1%	57.9%
		Combo 8	44.5%	43.9%	37.3%	38.1%
		Combo 9	39.9%	39.8%	33.6%	35.0%
		Combo 10	39.2%	39.3%	32.9%	34.9%
18	Immunizations for Adolescents	MCV4	65.1%	64.3%	60.3%	71.1%
		Tdap/TD	78.5%	76.4%	69.8%	84.4%
		Combo 1	61.6%	61.9%	58.1%	69.9%
19	Well-child visits in first 15 months of life	PHP	63.4%	46.5%	48.3%	52.2%
		MHC	62.5%	51.8%	55.4%	59.2%
		BCBS	62.3%	44.3%	47.9%	58.4%
		UHC	0.0%	0.0%	56.9%	68.9%
20	Well-child visits in third, fourth, fifth and sixth years of life	PHP	66.7%	54.9%	54.8%	55.6%
		MHC	66.5%	63.6%	68.8%	64.4%

Measure Number and Name		Description (as applicable)	2013 Baseline Value	DY1 Value	DY2 Value	DY3 Value
		BCBS	60.2%	56.6%	57.6%	55.8%
		UHC	0.0%	65.9%	52.6%	53.5%
21	Adolescent well care visits	PHP	48.1%	36.4%	32.3%	33.1%
		MHC	50.8%	51.7%	45.9%	47.7%
		BCBS	39.0%	36.3%	33.1%	32.3%
		UHC	N/A	31.1%	37.2%	32.1%
22	Prenatal and Postpartum care: timeliness of prenatal care and percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery	Prenatal	84.8%	73.0%	70.7%	76.8%
		Postpartum	61.3%	54.8%	51.2%	57.8%
23	Frequency of ongoing prenatal care		63.2%	52.1%	45.9%	55.8%
24	Breast cancer screening for women		54.5%	52.5%	50.7%	47.2%
25	Cervical cancer screening for women		54.8%	43.2%	48.7%	53.5%
27	Initiation and engagement of alcohol and other drug dependence treatment	Initiation of AOD	N/A	38.6%	37.7%	36.8%
		Engagement of AOD	N/A	14.0%	13.8%	13.5%
40	EPSDT screening ratio		0.82	0.82	0.84	N/A
41	Monitoring for patients on persistent medications		87.5%	84.0%	83.3%	83.6%
45	Medication Management for people with asthma		46.3%	46.3%	52.2%	53.5%
47	Asthma medication ratio		60.2%	52.2%	56.8%	57.1%
48	Adult BMI assessment; weight assessment for children/adolescents		74.2%	78.2%	76.0%	78.6%
49	Comprehensive Diabetes care	HbA1c Testing	83.5%	85.0%	84.1%	N/A
		HbA1c Poor Control (>9.0%)	47.9%	47.2%	49.8%	N/A
		HbA1c Control (<8.0%)	42.7%	43.4%	41.8%	N/A
		Eye Exam	50.4%	55.0%	51.8%	N/A
		Medical Attention for Nephropathy	76.6%	79.1%	87.3%	N/A
		Blood Pressure Controlled <140/90 mm Hg	62.0%	59.3%	58.4%	N/A
58	Antidepressant medication management	Effective Acute Phase Treatment	43.2%	55.6%	53.1%	50.4%
		Effective Continuation Phase Treatment	28.6%	41.1%	37.8%	34.9%

Measure Number and Name		Description (as applicable)	2013 Baseline Value	DY1 Value	DY2 Value	DY3 Value
74	Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications		83.7%	77.6%	77.9%	78.1%
75	Diabetes monitoring for people with diabetes and schizophrenia		62.4%	56.6%	49.9%	57.6%
106	Number and percentage of calls answered; answered within 30 seconds; call abandonment rate		90.6%	90.7%	90.4%	NR by MCOs