HEALTH CARE
AUTHORITY

State of New Mexico
Health Care Authority

Turquoise Care Medicaid Program
Managed Care Quality Strategy

Revised December 2024

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Program History

Prior to 1997, New Mexico Medicaid members received their care through a Fee-For-Service (FFS) model. The New Mexico Legislature mandated that the Human Services Department (HSD), Medical Assistance Division (MAD) implement a managed care program. A proposal was submitted under section 1915(b) of the Social Security Act to provide comprehensive medical and social services to New Mexico's Medicaid population.

On July 1, 1997, New Mexico implemented the Salud! program, a managed care program for physical health services. The program was designed to improve quality of care and access to care while making cost-effective use of state and federal funds. During that period, approximately 65% of Medicaid eligible members were participants in Salud!. In addition, the Medicaid safety net programs for children, including the Children's Health Insurance Program (CHIP) were combined into one program known as New Mexikids.

In 1999, HSD implemented the Personal Care Option (PCO) as a state plan service to meet the needs of Medicaid members in need of long-term services and who met a Nursing Facility Level of Care (NF LOC). PCO was developed to allow members to receive care in their home rather than being placed in a nursing facility.

In August 2002, A Health Insurance Flexibility and Accountability (HIFA) waiver was approved by the Centers for Medicare & Medicaid Services (CMS). The waiver program utilized unspent CHIP funds to provide basic health benefits for New Mexicans with incomes up to 200 percent of the federal poverty level through an employer-based buy-in insurance plan.

In 2004, the Interagency Behavioral Health Purchasing Collaborative (The Collaborative) was established as a pioneering effort in the behavioral health system transformation. The Collaborative had the authority to contract for behavioral health services and make decisions regarding the administration, direction and management of state-funded behavioral health care services in New Mexico. Optum Health, was selected as the Statewide Entity charged with the oversight of behavioral health care services for Medicaid recipients in Salud!.

On March 18, 2005, New Mexico signed the State Coverage Insurance Program (SCI) into law. SCI was an innovative insurance product, combining features of Medicaid and a basic commercial health plan. Support from the federal government provided the flexibility to offer coverage to the adults most in need throughout New Mexico.

In 2008, the Coordination of Long-Term Services (CoLTS) program was implemented as New Mexico's first managed long-term care program for Medicaid members who met a NF LOC. This 1915 (b) (c) concurrent program covered members residing in nursing facilities, participants of the Disabled & Elderly (D&E) waiver, Personal Care Option (PCO) members, dual eligible members and members with a qualified brain injury (BI). The program was an interagency collaboration between HSD and the New Mexico Aging and Long-Term Services Department (ALTSD). All acute, preventative and long-term care services were provided through contracted Managed Care Organizations (managed care organization). The primary goal of the program was to mitigate the array of problems resulting from the fragmentation of services provided to Medicare and Medicaid dual eligible members.

Centennial Care

By 2013, of the two million citizens in the state of New Mexico, approximately 520,000 people received their healthcare through the Medicaid program. The Medicaid program operated 12 separate waivers as well as an FFS program. Seventy percent of the Medicaid enrollees were in a managed care setting. Seven different health plans administered the various delivery systems. Services were provided under an umbrella of programs for eligible individuals in more than 40 eligibility categories.

In 2014, New Mexico embarked on a new path to deliver integrated care to the Medicaid population through a Section 1115 Demonstration Waiver known as Centennial Care. The 1115 Demonstration Waiver consolidated all previous federal waivers, with the exception of the three 1915(c) waivers. These include the Medically Fragile Waiver (MFW), the Developmentally Disabled Waiver, and the Mi Via Self-Directed Waiver for members who meet an ICF/IID level of care. Similarly, the number of managed care organization contracts were reduced from seven to four. The initial five-year demonstration period of Centennial Care, which began on January 1, 2014, was approved by CMS through December 31, 2018.

As part of the initial Centennial Care structure, Human Services Division contracted with four managed care organizations to administer the full array of services in an integrated model of care. The care coordination infrastructure was an integral focus of Centennial Care and promoted a person-centered approach to care with more than 800 care coordinators ensuring members receive services in the right setting when they need them. Centennial Care increased access to LTSS for people who previously needed a waiver allocation to receive such services by allowing any Medicaid member who meets a NF LOC to access Home and Community Based Services (HCBS). As a result, approximately 87% of members who meet a NF LOC are receiving services in the community.

In January 2014, simultaneously with the launch of Centennial Care, New Mexico became an expansion state under the Affordable Care Act. By the end of 2017, total enrollment in the Medicaid program had grown by 21.3%. Centennial Care has demonstrated improved utilization of health care services despite the significant enrollment growth.

In 2016 and 2017, New Mexico launched Health Homes in ten counties targeting individuals with Serious Mental Illness (SMI) or Severe Emotional Disturbance (SED). Health Home Core Services include comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow-up, individual and family support, and referral to community and social support services. Human Services Division required the managed care organization to work with providers to implement patient centered medical homes (PCMHs) resulting in an increase in members participating in a with over patient centered medical homes 333,925 members as of June 2018.

In December 2017, New Mexico submitted the 1115 Demonstration Waiver renewal application known as Centennial Care 2.0. On December 14, 2018. CMS approved a five-year extension for the New Mexico 1115 Medicaid demonstration effective January 1, 2019 through December 31, 2023.

On June 12, 2019, New Mexico submitted an amendment application requesting to remove the following authorities from the demonstration: authority to impose co-payment requirements; authority to implement monthly premiums for beneficiaries in the Adult Expansion Group with a household income above 100 percent of the Federal Poverty Level (FPL) and to terminate coverage and impose a lock-out for nonpayment of premiums; and beginning on February 8, 2020, the waiver of retroactive eligibility.

New Mexico also requested authority to increase the number of Community Benefit slots by 1,500 for individuals who are not otherwise eligible for Medicaid under the state plan and who meet a Nursing

Facility Level of Care, and to expand the Centennial Care Home Visiting pilot program. CMS approved the amendment on February 7, 2020.

On March 1, 2021, New Mexico submitted Amendment #2 of the 1115 Demonstration to request the following:

- Seek a waiver of the Institution for Mental Disease (IMD) exclusion for all Medicaid beneficiaries, specifically those with Serious Mental Illness (SMI)/Serious Emotional Disorder (SED), to maintain and enhance beneficiary access to behavioral health services in appropriate settings and ensure that individuals receive care in the facility most appropriate to their needs.

- Establish High-Fidelity Wraparound (HFW) as an intensive care coordination approach for children and youth who have high intensity needs.

- Create Graduate Medical Education (GME) expansion funding mechanism designed to develop new and/or expanded GME programs focusing on the specialties of General Psychiatry, Family Medicine, General Pediatrics, and General Internal Medicine.

- Add coverage of the Coronavirus (COVID-19) vaccine, to the extent not covered by the federal government during the period of Centennial Care 2.0 demonstration and its administration to individuals who have limited benefit plan coverage including Family Planning Category of Eligibility (COE), Emergency Medical Services for Aliens (EMSA), individuals covered under the COVID-19 uninsured population (FFCRA) and also those receiving only Pregnancy-related services.

On March 28, 2023, New Mexico received CMS approval of 1115 Demonstration Waiver Amendment #2 effective March 28, 2023 through December 31, 2023. The approval of this demonstration amendment enabled New Mexico to receive federal financial participation (FFP). CMS approved the implementation plan for inpatient, residential and other services provided to otherwise-eligible Medicaid beneficiaries while they are short-term residents in institutions for mental diseases (IMD) for diagnoses of serious mental illness (SMI) and/or serious emotional disturbance (SED). This amendment provided FFP for improvements to New Mexico's Home and Community Based Services (HCBS) and for the implementation of a High-Fidelity Wraparound (HFW) intensive care coordination benefit.

With the implementation of Centennial Care 2.0, New Mexico continued to advance new and successful initiatives under the demonstration. These initiatives addressed specific gaps in care and improve healthcare outcomes for Centennial Care Members. Key initiatives under the Centennial Care 2.0 program include:

- Refining care coordination to better meet the needs of high-cost, high-need members, especially during transitions in their setting of care;

- Continuing to expand access to Long Term Services and Support (LTSS) and maintain the progress achieved in rebalancing efforts to serve more members in their homes and communities;

- Improving the integration of behavioral and physical health services, with greater emphasis on other social factors that impact population health, improving the continuum of care for

substance use disorders, and providing supportive housing services for individuals with serious mental illness;

- Expanding payment reform through value-based purchasing (VBP) arrangements to achieve improved quality and better health outcomes;
- Continue the Safety Net Care Pool and Hospital Quality Improvement Initiative;
- Building upon policies that seek to enhance members' ability to become more active participants in their own health care, including the introduction of modest premiums for adults with higher income;
- Consolidate two different adult benefit packages into a single, comprehensive benefit package for most adults;
- Simplifying administrative complexities and implement refinements to program and benefit design; and
- Expanding the Medicaid program toward a more integrated model of behavioral health care delivery by providing Medicaid reimbursement for extended Institutions for Mental Diseases stays for individuals with Serious Mental Illness/Severe Emotional Disease.

Turquoise Care Development

On December 14, 2022, New Mexico Human Services Department presented New Mexico's Medicaid 1115 Demonstration Waiver renewal request (Turquoise Care) to the Centers for Medicare and Medicaid Services. The waiver renewal presented a Population Health approach to investigate deeper into the health-related social needs for New Mexicans. On July 25, 2024, the Centers for Medicaid and Medicare approved the renewal of Centennial Care 2.0 and renaming to Turquoise Care. The New Mexico Human Services Department made organizational changes of agencies and rebranded to New Mexico Health Care Authority. Therefore, New Mexico Health Care Authority revised the 2023 Centennial Care 2.0 Quality Strategy to reflect the 'significant changes' to the 1115 waiver renewal and expansion.[1] This quality strategy is a revision of the New Mexico Centennial Care 2.0 Quality Strategy.

Significant Program Changes

New Mexico Health Care Authority defines significant change as revising established procedures, assessment methodologies, contractual guidelines with managed care organizations, and enhancements to structural program implementation plans. As of July 2024, the Centers for Medicare and Medicaid has provided New Mexico a new set of standards and conditions therefore New Mexico is making the necessary revisions to meet all the outlined requirements.

[1] Dr. Scrase, D. J., & Comeaux, JD.,M.P.H., N. (2022). *Turquoise Care Section 1115 Medicaid Demonstration Waiver Renewal Request.* Turquoise Care Section 1115 Medicaid Demonstration Waiver Renewal Request, New Mexico Department of Human Services.

The following table lists the Turquoise Care program changes. This quality strategy is aligned with the 1115 Medicaid Demonstration Renewal Request to make efforts in reaching disadvantaged and populations most at risk. An additional change made to this demonstration period are the new managed care organizations participating in New Mexico Medicaid and Children's Health Insurance Program (CHIP). Molina Health Care and United Health Care are now participating managed care organizations for New Mexico members. Blue Cross Blue Shield and Presbyterian Health Plan are legacy managed care organizations who have been serving New Mexicans for numerous years.

Turquoise Care Program Changes	
Managed Care Organizations	Program Objectives
Blue Cross Blue Shield (BCBS) Presbyterian Health Plan (PHP) Molina Health Care (MHC) United Health Care (UHC)	• Legally responsible individuals provide personal care services on a long-term basis for Community Benefit and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit. • Increase enrollment slots by 1,000 for Community benefit members. • Provide continuous enrollment for children up to age six. • Expand home visiting models to incorporate four additional evidence-based models. • Increase supportive housing enrollment from 180 to 450 members annually. • Provide reentry services for eligible individuals for up to 90-days pre-release from a carceral facility. • Provide health related social need services for individuals meeting eligibility criteria for short-term post hospitalization housing and home delivered meals for pregnant individuals. • Expanded providers for the pre-tenancy/tenancy support program. • Expanded Community Benefit services to provide individuals meeting eligibility criteria up to two meals per day. • Coverage for traditional health care practices received through IHS, Tribal, or urban Indian organization facilities by Medicaid beneficiaries who are able to receive services delivered by or through these facilities.

Continuous Quality Improvement Model

In accordance with 42 CFR 438.340 and through a cross-reference of § 457.1240(e), New Mexico Health Care Authority will include goals and objectives for the continuous quality improvement model. New Mexico's Quality Strategy utilizes a continuous quality improvement (CQI) model to achieve goals and objectives. The Health Care Authority, through the quality management and quality improvement (QM/QI) standards, requires the managed care organizations to apply a continuous quality improvement model to identify opportunities for measurable improvements. Each managed care organization must have an established continuous quality improvement program. The model for improvement includes a variety of strategies.

In the Medicaid Managed Care Services Agreements (managed care organizations Contracts)[2] all the managed care organizations are informed of their responsibilities to comply with the terms outlined in the Turquoise Care Contract July 1, 2024-December 31, 2026. Within the contract details managed care organizations are given the guidance on conducting their internal quality management and quality improvement plans.

In this quality strategy plan, New Mexico Health Care Authority will utilize this quality improvement model to achieve the goals. The New Mexico Health Care Authority's mission is to ensure New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services. Working with our partners, we design and deliver innovative, high-quality health, supplemental food assistance, and income support services to improve the security and promote independence for New Mexicans. The overall goal of the Health Care Authority is for every New Mexican to access affordable health care coverage through a coordinated and seamless health care system.

New Mexico's goals for Turquoise Care are to build upon the program's accomplishments including providing the most effective and efficient health care possible for eligible New Mexicans. New Mexico Health Care Authority will hold leverage of purchasing power, create innovative polices and model for a comprehensive health care program to improve the well-being of New Mexicans and the workforce. New Mexico Health Care Authority is dedicated to achieving health equity by improving poverty, discrimination, and investing into areas with limited access to health facilities and providers. The quality improvement strategy for Turquoise Care will monitor the progress towards achieving the stated goals by applying measurable and relevant activities that focus on monitoring and assessing member outcomes. The Health Care Authority will monitor and assess the Medicaid and Children's Health Insurance Program (CHIP) through data-driven and evidence-based interventions that measure health-related social needs,1915c-like and 1915i-like outcomes.

The initiatives and quality monitoring are established as part of the Turquoise Care Health Care delivery system and align with the program goals and objectives listed in the table below:

Turquoise Care Goals and Objectives							
Goal 1: Build a New Mexico health care delivery system where every Medicaid member has a dedicated health care team that is accessible for both preventive and emergency care that supports the whole person - their physical, behavioral, and social drivers of health.							
Objective	**Objective Description**	**Quality Measure**	**Statewide Performance Baseline (year)**	**Statewide Performance Targets for Objective (year)**			**State Initiatives**
				CY25	**CY26**	**CY27**	
1.1	Increase access to well-child visits	Well-Child Visits in the First 15 Months of Life (W30)	CY25	54.50%	56.13%	57.76%	-Primary Care Payment Reform -Quarterly Performance Measure Monitoring -Value Based Payment Arrangements
		Well-Child Visits in the First 15-30 Months of Life (W30)	CY25	64.48%	66.11%	67.74%	

[2] Turquoise Care MCOs Contracts - New Mexico Health Care Authority (nm.gov)

Turquoise Care Goals and Objectives							
							-Continuous Enrollment for Children up to Age Six
1.2	Increase use of prenatal services	Prenatal and Postpartum Care (PPC)	CY25	80.69%	82.32%	83.95%	-Quarterly Performance Measure Monitoring -Value Based Payment Arrangements Expanded Home Visiting Program
1.3	Increase use of dental services	Oral Evaluation Dental Services (OED)	CY25	45.01%	46.64%	48.27%	-Quarterly Performance Measure Monitoring -Value Based Payment Arrangements -Continuous Enrollment for Children up to Age Six
1.4	Decrease hospital readmissions for mental illness	7-Day Follow up After Hospitalization for Mental Illness (FUH)	CY25	29.92%	31.55%	33.18%	-Quarterly Performance Measure Monitoring -Value Based Payment Arrangements -Medicaid Services for High-Need Justice-Involved Populations 30 Days Before Release
Goal 2: Strengthen the New Mexico health care delivery system through the expansion and implementation of innovative payment reforms and value-based initiatives.							
Objective	**Objective Description**	**Quality Measure**	**Statewide Performance Baseline (year)**	**Statewide Performance Targets for Objective (year)**			**State Initiatives**
				CY25	**CY26**	**CY27**	
2.1	Increase access to child and adolescent well-care visits	Child and Adolescent Well-Care Visits (WCV) 3-11 years of age	CY25	54.24%	55.87%	57.50%	-Primary Care Payment Reform -Quarterly Performance Measure Monitoring -Value Based Payment Arrangements -Continuous Enrollment for Children up to Age Six
		Child and Adolescent Well-Care Visits (WCV) 12-17 years of age	CY25	47.68%	49.31%	50.94%	
		Child and Adolescent Well-Care Visits (WCV) 18-21 years of age	CY25	23.73%	25.36%	26.99%	
Goal 3: Identify groups that have been historically and intentionally disenfranchised and address health disparities through strategic program changes to enable an equitable chance at living healthy lives.							
Objective	**Objective Description**	**Quality Measure**	**Statewide Performance Baseline**	**Statewide Performance Targets for Objective (year)**			**State Initiatives**

Turquoise Care Goals and Objectives							
			(year)	CY25	CY26	CY27	
3.1	Increase access to follow-up care for children prescribed ADHD medication	Follow-up Care for Children Prescribed ADHD Medication (ADD-E)	CY25	41.36%	42.99%	44.62%	-Quarterly Performance Measure Monitoring -Value Based Payment Arrangements
3.2	Increase the adherence of pharmacotherapy for members with opioid use disorder	Pharmacotherapy for Opioid Use Disorder (POD)	CY25	25.22%	26.85%	28.48%	-Quarterly Performance Measure Monitoring -Value Based Payment Arrangements -Medicaid Services for High-Need Justice-Involved Populations 30 Days Before Release
3.3	Decrease the percentage of members 18–75 years of age with poor control of their HbA1c	Glycemic Status Assessment for Patients with Diabetes (GSD)	CY25	42.60%	40.97%	39.34%	-Home Delivered Meals Pilot -State Directed Payments -Value Based Payment Arrangements -Medicaid Services for High-Need Justice-Involved Populations 30 Days Before Release
3.4	To reduce the adverse effects of unmanaged diabetes	Kidney Health Evaluation for Patients with Diabetes (KED)	CY25	32.28%	33.91%	35.54%	--Home Delivered Meals Pilot -Value Based Payment Arrangements -Medicaid Services for High-Need Justice-Involved Populations 30 Days Before Release

Quality Strategy Evaluation

The quality strategy is evaluated annually by the state's external quality review organization in the Annual Technical Report. This evaluation ensures alignment with reported outcomes from external quality review validation reports, managed care organizations' audited Healthcare Effectiveness Data and Information Set reports, Consumer Assessment of Healthcare Providers and Systems surveys, Section 1115 Waiver Evaluation report, New Mexico Health Care Authority internal audits and managed care organization reports. The external quality review organization evaluation assesses how the New Mexico Health Care Authority can target the goals, and the objectives outlined in the quality strategy to better support improvement in the quality, timeliness, and access to health care services provided to Turquoise Care enrollees. The external quality review organization recommendations will be utilized to gauge effectiveness of the Quality Strategy and to determine if any necessary changes or updates to the Quality

Strategy are warranted. The external quality review Annual Technical Report is posted to the New Mexico Health Care Authority website annually: New Mexico Centennial Care External Quality Review Report for Measurement Year 2022. More details are provided in the External Quality Review section of this document.

Turquoise Care Quality Metrics and Strategies

Performance Measures

New Mexico selects quality metrics and performance targets by assessing gaps in care within the State's Medicaid population. New Mexico Health Care Authority monitors and utilizes data that evaluate the managed care organizations' strengths and opportunities for improvement by specifying performance measures (PMs) and target measures (TMs). The selected performance measures and tracking measures are based on industry standards and consistent with The Centers for Medicare and Medicaid external quality review protocols. The Health Care Authority conducts quarterly monitoring of the performance measures to determine trending and to identify risks to meeting the specified performance targets. The specifications and outcomes are shared with the managed care organizations during the quarterly quality meetings and posted on the New Mexico Health Care Authority website. https://www.hca.nm.gov/external-quality-review-organization-eqro-reports/.

All performance measures (PMs) and targets are based on Healthcare Effectiveness Data and Information Set (HEDIS) technical specifications for the current reporting year. The managed care organizations shall meet performance targets specified by the Health Care Authority. The performance measures will be revised to meet New Mexico Health Care Authority designated targets for Calendar Year (CY) 2024, 2025, and 2026. Performance Measures are based on National Committee for Quality Assurance (NCQA) and Healthcare Effectiveness Data and Information Set technical specifications for the current reporting year unless otherwise specified by New Mexico Health Care Authority. The strategy for unmet target penalties is an established method for penalizing managed care organizations for not meeting specific target rates. The targets are for three years steward of the calendar year 2022 National Committee for Quality Assurance National Average. New Mexico Health Care Authority calculates an average increase for each calendar year until reaching the calendar year Quality Compass National Average plus one percentage point. Failure to meet the state's designated target for the individual performance measures during the calendar year will result in a monetary penalty based on three percent of the total capitation paid to the managed care organization for the contract/agreement year, divided by the number of performance measures specified in contract/agreement.

Turquoise Care Performance Measures					
PM #1 Well-Child Visits in the First 30 Months of Life (W30) (two indicators):	Measure Steward	CY22 National Average	CY25 Target	CY26 Target	CY27 Target
1. The percentage of members who turned 15 months old during the measurement year and had six or more well-child visits.	NCQA HEDIS	56.76%	54.50%	56.13%	57.76%
2. The percentage of members who turned 30 months old during the measurement year and had two or more well-child visits.		66.74%	64.48%	66.11%	67.74%
PM #2 Child and Adolescent Well-Care Visits (WCV) (three indicators):	Measure Steward	CY22 National Average	CY25 Target	CY26 Target	CY27 Target

Turquoise Care Performance Measures					
The percentage of members 3 - 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.					
1. 3-11 years of age	NCQA HEDIS	56.50%	54.24%	55.87%	57.50%
2. 12-17 years of age		49.94%	47.68%	49.31%	50.94%
3. 18-21 years of age		25.99%	23.73%	25.36%	26.99%
PM #3 Prenatal and Postpartum Care (PPC) (two indicators):	Measure Steward	CY22 National Average	CY25 Target	CY26 Target	CY27 Target
1. Timeliness of Prenatal Care: The percentage of deliveries in which members had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment.	NCQA HEDIS	82.95%	80.69%	82.32%	83.95%
2. Postpartum Care: The percentage of deliveries in which members had a postpartum visit on or between seven and 84 days after delivery.		76.96%	74.70%	76.33%	77.96%
PM #4 Oral Evaluation Dental Services (OED): The percentage of members under 21 years of age, who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year.	Measure Steward	CY22 National Average	CY25 Target	CY26 Target	CY27 Target
	NCQA HEDIS	47.27%	45.01%	46.64%	48.27%
PM #5 Follow up After Hospitalization for Mental Illness (FUH) (7 Day): The percentage of discharges for members six (6) years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnosis and who had a follow-up visit with a mental health practitioner within 7 days after discharge.	Measure Steward	CY22 National Average	CY25 Target	CY26 Target	CY27 Target
	NCQA HEDIS	32.18%	29.92%	31.55%	33.18%
PM #6 Breast Cancer Screening (BCS): The percentage of members 50-74 years of age who had at least one mammogram to screen for breast cancer in the past two years.	Measure Steward	CY22 National Average	CY25 Target	CY26 Target	CY27 Target
	NCQA HEDIS	52.43%	50.17%	51.80%	53.43%
PM #7 Follow-up Care for Children Prescribed ADHD Medication (ADD-E) (Initiation Phase): The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase.	Measure Steward	CY22 National Average	CY25 Target	CY26 Target	CY27 Target
	NCQA HEDIS	43.62%	41.36%	42.99%	44.62%
PM #8 Immunizations for Adolescents (IMA): The percentage of members 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human	Measure Steward	CY22 National Average	CY25 Target	CY26 Target	CY27 Target
	NCQA HEDIS	35.55%	33.29%	34.92%	36.55%

Turquoise Care Performance Measures					
papillomavirus vaccine series by their 13th birthday.					
PM #9 Pharmacotherapy for Opioid Use Disorder (POD): The percentage of opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days among members 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event.	Measure Steward	CY22 National Average	CY25 Target	CY26 Target	CY27 Target
	NCQA HEDIS	27.48%	25.22%	26.85%	28.48%
PM #10 Glycemic Status Assessment for Patients with Diabetes (GSD): The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was >9.0% (poor control) during the measurement year. (lower is better)	Measure Steward	CY22 National Average	CY25 Target	CY26 Target	CY27 Target
	NCQA HEDIS	40.34%	42.60%	40.97%	39.34%
PM #11 Eye Exam for Patients with Diabetes (EED): The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.	Measure Steward	CY22 National Average	CY25 Target	CY26 Target	CY27 Target
	NCQA HEDIS	51.47%	49.21%	50.84%	52.47%
PM #12 Kidney Health Evaluation for Patients with Diabetes (KED): The percentage of diabetic members 18-85 years of age who received an annual kidney health evaluation, including a blood test for kidney function (estimated glomerular filtration rate [eGFR]) and a urine test for kidney damage (urine albumin-creatinine ratio [uACR]) during the measurement year.	Measure Steward	CY22 National Average	CY25 Target	CY26 Target	CY27 Target
	NCQA HEDIS	34.54%	32.28%	33.91%	35.54%
PM #13 Lead Screening in Children (LSC): The percentage of members two years of age who had one or more capillary or venous blood test for lead poisoning by their second birthday.	Measure Steward	CY22 National Average	CY25 Target	CY26 Target	CY27 Target
	NCQA HEDIS	59.36%	57.10%	58.73%	60.36%

Abbreviations: National Committee for Quality Assurance (NCQA) and HealthCare Effectiveness Data and Information Set (HEDIS).

Tracking Measures

New Mexico has directed the managed care organizations to report on tracking measures that focus on specific target populations to monitor and implement interventions for improvement, if needed. The tracking measures are based on the selected HealthCare Effectiveness Data and Information Set, Adult Core Set or state defined technical specifications. The Health Care Authority analyzes the tracking measures to identify performance trends, best practices, gaps in care and managed care organizations' interventions. Feedback is shared and discussed with the managed care organizations during quarterly quality workgroup meetings. The tracking measure reports are subject to sanctions including non-monetary sanctions and

monetary penalties, based on noncompliance in the contract/agreement to the extent authorized by State and federal law.

Tracking Measures (non-penalty)	
Measure Name	Measure Steward
TM #1 - Smoking Cessation Indicator 1: Total number of unduplicated members receiving smoking and tobacco cessation products/services (nicotine replacement, counseling services, quit line, and medications) Indicator 2: Total number of units for smoking and tobacco cessation products and services Indicator 3: Total dollar amount for smoking and tobacco cessation products and services Indicator 4: Total of unduplicated members receiving smoking and tobacco cessation products/services, nicotine replacement, counseling services, quit line, and medications who have successfully quit smoking.	State Defined
TM #2 - Childhood Immunization Status (CIS) (Combination 3): The percentage of members two years of age who had the following vaccinations: (4) DTaP, (3) IPV, (1) MMR, (3) HiB, (3) HepB, (1) VZV, and (4) PCV by their second birthday	Healthcare Effectiveness Data and Information Set (HEDIS)
TM #3 - Follow-Up After ED Visit for Mental Illness (FUM) (7 Day): The percentage of emergency department visits for members six years of age and older with a principal diagnosis of mental illness or intentional self-harm who received a follow-up visit for mental illness within seven days of the ED visit.	Healthcare Effectiveness Data and Information Set (HEDIS)
TM #4 - Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) (two indicators): The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. Indicator 1: 12 -17 years of age Indicator 2: 18 years of age and older	Healthcare Effectiveness Data and Information Set (HEDIS)
TM #5 - Cervical Cancer Screening (CCS): The percentage of women 21-64 years of age who were screened for cervical cancer.	Healthcare Effectiveness Data and Information Set (HEDIS)
TM #6 - Statin Therapy for Patients with Diabetes (SPD) and cardiovascular disease (SPC) (four indicators): The percentage of members with Diabetes and Cardiovascular Disease who received and adhered to statin therapy. Indicator 1: Diabetes (SPD) Received Statin Therapy Indicator 2: Diabetes (SPD) 80% Adherence Indicator 3: Cardiovascular disease (SPC) Received Statin Therapy Indicator 4: Cardiovascular disease (SPC) 80% Adherence	Healthcare Effectiveness Data and Information Set (HEDIS)
TM #7 - Contraceptive Care for Women (four indicators): The percentage of members provided most effective or moderately effective method of contraception, or a long-acting reversible method of contraception (LARC). Indicator 1:15-20 years of age (CCW) Indicator 2: 21-44 years of age (CCW) Indicator 3: Postpartum, 15-20 years of age (CCP) Indicator 4: Postpartum, 21-44 years of age (CCP)	Health and Human Services (HHS) Office of Population Affairs

Tracking Measures (non-penalty)	
TM #8 - Initiation and Engagement of Substance Use Disorder (IET): Indicator 1: Initiation Phase: The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visits or medication treatment within 14 days. Indicator 2: Engagement Phase: The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.	Healthcare Effectiveness Data and Information Set (HEDIS)
TM #9 - Prenatal Depression Screening and Follow-Up (PND-E): The percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care.	Healthcare Effectiveness Data and Information Set (HEDIS)
TM #10 - Postpartum Depression Screening and Follow-up (PDS-E) The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period.	Healthcare Effectiveness Data and Information Set (HEDIS)
TM #11 - Diabetes Short Term Complications Admission Rate: The percentage of discharges with a principal ICD-10 diagnosis code for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma). (lower is better)	Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicator (PQI)

Abbreviations: National Committee for Quality Assurance (NCQA) and HealthCare Effectiveness Data and Information Set (HEDIS)

Auto-Assignment Algorithm

New Mexico Health Care Authority has developed an auto assignment algorithm that aligns with selected HealthCare Effectiveness Data and Information Set based performance measures to incentivize managed care organizations to meet annual targets. The auto-assignment algorithm consists of eight HealthCare Effectiveness Data and Information Set (HEDIS) based measures and sub-measures worth a total of eleven points. Each measure and sub-measures are assigned a quarterly performance target. The managed care organizations will receive one point for each target met during the quarter for reaching each target. The managed care organizations with the highest number of points received at the end of each quarter will be rewarded with the auto-assignment for the three months following.

The auto-assignment algorithm applies the following criteria to the selected metrics:

- Metric alignment with the Health Care Authority's focus on targeted populations
- Measures that are lagging in performance
- Ease of data collection as it aligns with the Health Care Authority's current quarterly monitoring cadence
- Current Performance Measure or Tracking Measure with the Health Care Authority's quarterly and annual assigned target

Utilization Management Standards

New Mexico Health Care Authority requires the managed care organizations to establish and implement a utilization management (UM) system that follows the National Committee for Quality Assurance (NCQA) utilization management standards, promotes quality of care, adherence to standards of care,

efficient use of resources, member choice, and the identification of service gaps within the service systems managed care organizations must comply with State and federal requirements for utilization management.

- Maximize the effectiveness of care by evaluating clinical appropriateness and authorizing the type and volume of services through fair, consistent, and culturally competent decision-making processes while ensuring equitable access to care and a successful link between care and outcomes.

- Submit to New Mexico Health Care Authority on an annual basis the utilization management edits in the managed care organization claims processing system that control utilization and prevent payment for claims that are duplicates, unbundled when they should be bundled, or already covered under another charge.

The managed care organizations must define and submit annually to the state a written copy of their utilization management program description, work-plan, and evaluation and shall include, but not be limited structure and accountability mechanisms:

1. A description of how the work-plan supports the goals described in the program description and specific indicators that will be used for periodic performance tracking and trending as well as processes or mechanisms used for assessment and intervention.

2. The work-plan must be data driven with key indicators that are used to ensure that under-and over utilization are detected by the managed care organizations and addressed appropriately.

3. Implement a comprehensive utilization management program evaluation that includes an evaluation of the overall effectiveness of the program, an overview of activities and an assessment of the impact of the program on management and administrative activities.

The review and analysis of any impact from the previous year shall be incorporated in the development of the following year's work-plan.

- Ensure the involvement of appropriate, knowledgeable, currently practicing practitioners in the development of procedures.

- Submit to the Health Care Authority the proposed utilization management clinical criteria to be used for services requiring prior authorization.

- Upon request, the managed care organizations shall provide decision criteria to providers, members, their families and the public.

- Define how decisions will be communicated to the member and the member's primary care providers or to the provider requesting the authorization.

- Comply with the most rigorous standards or applicable provisions of either the National Committee for Quality Assurance, New Mexico Health Care Authority's regulation, or the Balanced Budget Act of 1997 or 42 CFR Part 438 related to timeliness of decisions including routine/non-urgent and emergent situations.

- Ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise to understand the treatment of the member's condition or disease, such as the managed care organization's medical director.

- Approve or deny covered services for routine/non-urgent and urgent care requests, requested by either members or providers, within the time frames stated in regulation. These required time frames shall not be affected by a "pend" decision. The decision-making time frames must accommodate the clinical urgency of the situation and must not result in the delay of the provision of covered services to members beyond state-specified time frames.

- Develop and implement policies and procedures by which decisions may be appealed by members or their representatives in a timely manner, which must include all necessary requirements and time frames based on all applicable federal and state statutes and regulations.

- Comply with utilization management reporting requirements.

    - Ensure that the Pharmacy and Therapeutics Committee membership includes behavioral health expertise to aid in the development of pharmacy and practice guidelines for primary care providers regarding psychotropic and antidepressant medications; and

    - Develop and implement policies and procedures to issue extended prior authorization for covered services provided to address chronic conditions that require ongoing care. These services shall be authorized for an extended period and the managed care organizations shall provide for a review and periodic update of the course of treatment, according to best practices.

Each managed care organization is responsible for adhering to the following standards of care and efficient use of the service systems:

- Ensure that members receive services based on their current condition and effectiveness of previous treatment.

- Ensure that services are based on the history of the problem/illness, its context, and desired outcomes; assist members and/or their representatives in choosing among providers and available treatments and services.

- Ensure the use of the least restrictive setting for crisis response and stabilization, emphasizing relapse and crisis prevention, not just crisis intervention.

- Detect over- and under-utilization of services to assess the quality and appropriateness of services furnished to members with special health care needs, and to identify health care disparities for remediation;

- Inform the state of Population Health Management strategies and activities.

- Accept the New Mexico Uniform Prior Authorization Form for nonemergency medical and pharmaceutical benefits, as required per the 2019 New Mexico Health Insurance Prior Authorization Act.

- Respond to prescription drug prior authorization requests in accordance with New Mexico Administrative Code 8.308.9.26.E(7)(a)(b); Ensure that prior authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits as specified in 42 C.F.R. § 438.910(d); and

- Ensure that prior authorization is not required for service codes specified by the Health Care Authority.

Managed Care Organization Accreditation Standards

As part of the Turquoise Care Medicaid Managed Care Contract (Effective July 1, 2024) New Mexico Health Care Authority is requiring each managed care organization to obtain a National Committee for Quality Assurance Distinction in Multicultural Health Care/ Health Equity and Long-Term Services and Supports Distinction Accreditation. Details are outline at the link shared in Section 3 of the contract – Administrative Requirements/Requirements Prior to Operation. Turquoise Care MCOs Contracts - New Mexico Health Care Authority (nm.gov). Failure to meet the accreditation standards and/or failure to attain or maintain accreditation is considered a breach of the managed care organization's contract with the Health Care Authority. Violation, breach or noncompliance with the accreditation standards may be subject to termination for cause as detailed in the contract. The managed care organization's accreditation status is reviewed annually by the external quality review organization and included in state's Annual Technical Report. https://www.hca.nm.gov/external-quality-review-organization-eqro-reports/

Performance Improvement Projects (PIPs) and Interventions

New Mexico identifies Performance Improvement Projects (PIPs) by assessing gaps in care with a focus on applying sustainable interventions that will improve the access, quality, or timeliness of care and services provided to the State's Medicaid Beneficiaries. The performance improvement projects and interventions are included in the managed care organization's contracts. They are revised and updated based on New Mexico's Health Care Authority's review of the positive outcomes or the identification of the needed attention toward specific gaps in care.

The Health Care Authority requires that each managed care organization implement work-plans and activities consistent with performance improvement projects and interventions as required by 42 CFR 438.330 and Quality Assessment and Performance Improvement Program. The managed care organization is directed to design sound and meaningful quality interventions to have a significant impact managed care Medicaid member. The managed care organizations may select interventions that are specific to the needs of the targeted populations. The state's external quality review organization will conduct annual performance improvement project validations on behalf of the state to determine managed care organization compliance. The annual validation reviews are posted to the New Mexico Health Care Authority website. https://www.hca.nm.gov/external-quality-review-organization-eqro-reports/

The following are Performance Improvement Project Topics established by New Mexico Health Care Authority for managed care organizations to conduct activities on.

1. Expand Access to Assisted Living for Medicaid Members

2. Enhanced Services for 12 Months for Prenatal and Postpartum Mothers with Substance Use Disorder

3. Expanding/Enhancing the State's OB/GYN Provider Network OB Deserts in the Rural and Frontier Regions

4. Improving Well Visits and Immunizations for Children and Adolescents

5. Hepatitis C Treatment (Access to Medications)

Managed care organizations are required to address at least one clinical aspect of care and one non-clinical aspect of care; include aims to improve access to care; report standardized performance indicators; and report targets for improvement to demonstrate statistical improvement.

PIP Topics	Performance Improvement Project (PIPs)
Expand Access to Assisted Living for Medicaid Members	• Percentage of members residing in urban counties with access to assisted living facilities. (Access as defined by the Health Care Authority.) • Percentage of members residing in rural counties with access to assisted living facilities. (Access as defined by the Health Care Authority.) • Percentage of members residing in frontier counties with access to assisted living facilities. (Access as defined by the Health Care Authority.) • Number of urban county assisted living facilities in network. • Number of rural county assisted living facilities in network. • Number of frontier county assisted living facilities in network. • Number of unique members utilizing assisted living facilities
Enhanced Services for 12 Months for Prenatal and Postpartum Mothers with Substance Use Disorder	• Percent of clinics outreached and expanding telehealth services in rural community clinics and opioid treatment programs in the measurement year (Measure Year 2024). • Percent of pregnant and postpartum members with any substance use disorder provided a Deterra medication disposal bag and/or Rxlocking cap in the measurement year (Measure Year 2024). • This indicator combines the percentage of members with newly identified substance use disorder episode that result in treatment initiation (IET) with members who are pregnant or experiencing postpartum in the measurement year (Measure Year 2024). The IET member list is matched with the list of members who received prenatal or postpartum care (PPC). • This indicator combines the percentage of members with newly identified substance use disorder (SUD) episodes that result in treatment engagement (IET) with members who are pregnant or experiencing postpartum in the measurement year (Measure Year 2024). The IET member list is matched with the list of members who received prenatal or postpartum care (PPC).

PIP Topics	Performance Improvement Project (PIPs)
Expanding/Enhancing the State's OB/GYN Provider Network OB Deserts in the Rural and Frontier Regions	• Percentage of women residing in rural and frontier counties ages 12 and older with at least one visit to an OB/GYN provider within the measurement year. • Percentage of women residing in rural and frontier counties ages 12 and older that have adequate access to OB/GYN (adequate access is the state standard) • Adult CAHPS: Getting appointments with a specialist as soon as needed
Improving Well Visits and Immunizations for Children and Adolescents	• HEDIS Child and Adolescent Well-Care Visits • HEDIS Childhood Immunization Status – Combination 3 • HEDIS Immunization for Adolescents • HEDIS Well-Child Visits in the First 30 Months of Life • Child CAHPS: How often was it easy to get the care, tests, or treatment your child needed?
Hepatitis C Treatment (Access to Medications)	• Percent of members receiving full course of Hep C Medication on first fills. • Percent of initial Hep C claims processed by Pharmacies from total Hep C drugs processed. • CAHPS Health Plan Survey Adult Version in the last 6 months, how often was it easy to get the care, tests, or treatment you needed?
PIP Topic related to CISC	• Percentage of CISC members who have an ADHD diagnosis and missing dental care.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

New Mexico incorporates the Consumer Assessment of Healthcare Providers and Systems required by National Committee for Quality Assurance for managed care organizations' accreditation. They are required to submit annual report submissions. CAHPS 5.0H allows for inclusion of state-specific questions, which currently focus on the members' satisfaction with the care coordination services received from the managed care organizations. The results of the annual CAHPS survey are reviewed and analyzed by the Health Care Authority to determine gaps in member satisfaction. Results are discussed with the managed care organizations during quarterly quality meetings. The managed care organizations are also asked to provide a summary of interventions and strategies aimed at addressing gaps and improving member satisfaction. The annual CAHPS reports are posted to New Mexico Health Care Authority's website. https://www.HCA.state.nm.us/lookingforinformation/cahps-reports/

Care Coordination and Transition of Care Standards

Care Coordination

New Mexico Health Care Authority fosters a comprehensive care coordination model. The goal is to ensure Medicaid members receive the right care, at the right time, and in the right setting. Managed care organizations determine the levels of care coordination for each member based on a standardized assessment. This standardized tool is used to identify the level of support that is most appropriate to meet members' individualized needs. New Mexico Health Care Authority requires the managed care organizations or their delegate, to conduct a standardized health risk assessment on members who are newly enrolled in Turquoise Care or who do not have a care coordination level. The health risk assessment will indicate if a member requires a comprehensive needs assessment to determine if the member should be assigned to a care level. The care coordination standardized assessment tools are consistent and objective therefore the results of the assessments are effective and accurate. The process of the care coordination model is standardized but also meets individual needs of each member.

- Standardized Health Risk Assessment (HRA)
    - Conducting health risk assessments (HRA) for members who are newly enrolled in Turquoise Care or Members who have had a change in circumstance or change of health conditions or that requires an assessment for a higher level of care and who are not currently identifies for Care Coordination on Level 1 or 2 services, including those with retroactive eligibility.
    - Competencies will be evaluated in the following areas, but not limited to nursing level of care assessments and reassessments occur on schedule in compliance with the agreement and are submitted to the lead or supervising care coordinator.

- Standardized Comprehensive Needs Assessment (CNA)
    - Assess each member's physical, behavioral, functional and psychosocial needs.
    - Identifying the specific medical, behavioral, long-term services and supports, and other social support services (e.g., housing, transportation or income assistance) necessary to meet the member's needs.
    - Comprehensive needs assessments are conducted initially, semiannually, annually, or upon a change in health conditions that may warrant a higher level of care
    - Assess members for long-term services and supports needs. This applies to members of all ages who have functional limitations and/or chronic illnesses. The primary purpose is to

support the ability of the member to receive services in the setting of their choice, which may include the individual's home, a provider-owned or controlled residential setting, a nursing facility, or institutional setting.

- Identifying members with special health care needs:
  New Mexico Health Care Authority defines members with special health care needs as those who have or are at increased risk for a disease, defect or medical condition that may hinder the achievement of normal physical growth and development and who also require health and related services of a type or amount beyond that required by individuals.
- Ensure timely access and provision of services needed to help each member maintain or improve his or her physical and/or behavioral health status or functional abilities while maximizing independence.
- Facilitate access to other social support services and assistance needed to promote each member's health, safety, and welfare.

- Nursing Facility Level of Care (NF LOC)

  - Members who have indicators that may warrant a nursing facility level of care (NF LOC), the managed care organization will conduct a comprehensive needs assessment and use the New Mexico Nursing Facility Level of Care Criteria and Instructions to determine nursing facility level of care eligibility for members in need of home and community-based services (HCBS) or nursing facility care. The results of the comprehensive needs assessment and nursing facility level of care assessment will be used to create the comprehensive care plan (CCP) that include home and community-based services.

- Comprehensive Care Plan (CCP)
  - Developed and updated on schedule in compliance with the Agreement.
  - Reflect needs identified in the comprehensive needs assessment and reassessment process.
  - Goals are member centric and agreed upon by the member.
  - Appropriate and adequate to address the member's needs including the need for all Community Benefit (CB) services.
  - Services are delivered in a person-centered, holistic, strength-based, and well-coordinated manner as described in the care coordination plan and authorized by the managed care organization.
  - Services are appropriate to address the member's needs; including culturally responsive treatments and supports for Native American children and youth in CYFD Protective Services (PS) custody.
  - Ensure services are delivered and utilized appropriate.
  - Monitored for service gaps and address services needs.

Transitions of Care

New Mexico Health Care Authority is committed to providing the necessary supports to assist Medicaid members and requires the managed care organizations establish policies and procedures that adhere to the standards defined by the Managed Care Policy Manual Managed Care Policy Manual - New Mexico Health Care Authority (nm.gov) and contracts. The managed care organizations are required to facilitate and ensure a timely and seamless transition for all Medicaid members transitioning to new services or service providers without any disruptions in services. The managed care organizations must identify and facilitate coordination of care for all members during various transition scenarios.

The methods for identification of members in need of care coordination during a transition of care shall include, at a minimum:

- The Comprehensive Needs Assessment CNA;
- Pre-Admission Screening and Resident Review (PASRR);
- Minimum Data Set (MDS);
- Provider referral including hospitals and Residential Treatment Centers (RTCs);
- Ombudsman referral;
- Family member referral;
- Change in medical status;
- Member self-referral;
- Community reintegration referral;
- State agency referral; and/or
- Incarceration or detention facility referral.

For members who are candidates for transition to the community, the care coordinator shall facilitate the development and completion of a transition plan which shall remain in place for a minimum of sixty (60) calendar days, or until the transition has occurred and a new comprehensive care plan is in place.

The transition plan shall address the member's transition needs including but not limited to:

- Physical and Behavioral Health needs;
- Community Benefit needs;
- Selection of Providers in the community;
- Housing needs;
- Financial needs;
- Interpersonal skills;
- Safety; and
- Continuation of Medicaid eligibility.

The managed care organizations will conduct additional assessments within seventy-five (75) calendar days of a transition to determine if the transition was successful and identify any remaining needs. Transition scenarios include but are not limited to:

- Transition from a nursing facility to the community;

- Transition for member(s) with special circumstances;
- Transition for member(s) moving from a higher level of care to a lower level of care;
- Transition for member(s) turning twenty-one (21) years of age, and out of early periodic screening diagnostic treatment (EPSDT) services
- Transition for member(s) changing managed care organizations while hospitalized;
- Transition for member(s) changing managed care organizations during major organ and tissue transplantation services;
- Transition for member(s) changing managed care organizations while receiving outpatient treatment for significant medical conditions;
- Transition for member(s) changing managed care organizations;
- Transition for member(s) moving from a residential placement or institutional facility to a community placement;
- Transition for children returning home from a foster care placement;
- Transition for member(s) released from incarceration or detention facilities;
- Transition for member(s) discharging from a hospital;
- Transition for member(s) discharging from out-of-home placements and crisis centers related to behavioral health treatment;
- Transition for member(s) who are preparing to receive out-of-state treatment; and/or
- Transition for member(s) from Fee for Service (FFS).

Transition of Care for Justice-Involved Individuals

The managed care organizations are required to participate in care coordination efforts for justice-involved individuals to facilitate the transition of members from prisons, jails, and detention facilities into the community. This includes tribal communities and reservations for Native American members transitioning from incarceration. Care coordination should occur prior to release, including when release from the facility occurs after business hours or on non-workdays. The managed care organization will collaborate with criminal justice partners to identify justice-involved members with physical and/or behavioral health chronic and/or complex care needs prior to the member's release.

New Mexico Health Care Authority requires each managed care organization to at minimum address:

- Initiate a state approved transition of care (TOC) assessment with the member prior to the member's release or within three (3) business days of notification of member's release.
- Develop a transition of care plan, derived from the transition of care assessment, with the member and/or member's representative's participation that addresses, at a minimum:
  - Physical and Behavioral Health needs

- Community Benefit needs
- Selection of providers in the community
- Housing needs
- Financial needs;
- Continuation of Medicaid eligibility
- Interpersonal skills
- Safety

The Health Care Authority requires the transition of care plan to remain in place for a minimum of sixty (60) calendar days from the members release or sixty (60) calendar days from notification of members' release. The managed care organization shall develop and implement policies and procedures for ensuring that members released from incarceration or detention facilities transition successfully back into the community and at a minimum conduct a health risk assessment within three (3) business days of member's release or three (3) business days of notification of member's release.

The managed care organizations are required to coordinate with the discharge planning teams at hospitals and institutions (e.g. Nursing Facilities, Jails/Prisons, Juvenile Detention Centers, RTCs) to address at a minimum:

- Need for Home and Community Based Services;
- Follow up appointments;
- Therapies and treatments;
- Medications; and
- Durable medical equipment.

Transition of Care for Comprehensive Addition and Recovery Act (CARA)Members

Each managed care organization will develop and implement policies and procedures to ensure care coordinators assist in addressing the needs of pregnant mothers and fathers with opioid use disorders and their infants. Once the member is referred to a managed care organization by the Department of Health (DOH) or a hospital, a managed care organization care coordinator will be responsible for assessing, referring, and coordinating support services. Through the process of identification and qualification as a Comprehensive Addiction and Recovery Act (CARA) member and specific plan of care will be created. The care coordinators are responsible for collaborating and coordinating care for the infant, affected mother/father and family and caregivers in accordance with the Children, Youth and Families Department (CYFD). New Mexico Health Care Authority will monitor and track the trends in transitions of care for to identify areas to strengthen this service via informational and numbered reports submitted by each managed care organization.

Health Disparities Strategic Plan

New Mexico is making Healthy Equity a priority by initiating many strategies to contribute to health disparities, including access to health care, behavioral choices, genetic predisposition, geographic location, poverty, environmental and occupational conditions, language barriers and social and cultural factors. The state of New Mexico is committed to in promoting health care equity in the delivery of covered services to all Medicaid beneficiaries in a culturally sensitive of gender, sexual orientation, or gender identity and including members who have a hearing impairment, limited English proficiency, a speech or language disorder, physical disabilities, developmental disabilities, differential abilities and diverse cultural and ethnic backgrounds.

New Mexico Health Care Authority incorporates a variety of methodologies and resources such as stratified member enrollment files and reports from the managed care organizations. Stratified data tracking allows New Mexico Health Care Authority to direct interventions and monitoring for those populations most at-risk and in-need.

The established definition of "disability status" follows State of New Mexico Governor's Commission on Disability, NM State Register/ Volume XXIX, Issue 24 / December 27, 2018, Title 9 Human Rights Chapter 4 Persons with Disabilities Part 20 Governor's Commission on Disability Rules:

> "F. "Disability" means a physical or mental impairment that substantially limits one or more of the major life activities such as caring for oneself, walking, toileting, etc. 9.4.20 NMAC[3]". New Mexico Register / Volume XXIX, Issue 24 / December 27, 2018

As per the managed care organizations and The Health Care Authority contracts dual eligible(s) means individuals who – by reason of age, income, and/or disability – qualify for Medicare and full Medicaid benefits under Section 1902(a)(10)(A) or 1902(a)(10)(C) of the Social Security Act, under Section 1902(f) of the Social Security Act or under any other category of eligibility (COE) for medical assistance for full benefits. Dual Eligible Special Needs Plans (D-SNP) means plans that enroll members who are entitled to both Medicare (Title XVIII) and Medical Assistance from a State Plan under Title XIX (Medicaid) and offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid.

Strategy 1: The Health Care Authority and the managed care organizations are following all required federal mandatory reporting on stratified data. The Health Care Authority is updating their systems and working closely with contract vendors to ensure the data is categorized to help identify at-risk populations and programs. The Health Care Authority requires managed care organizations to capture this information under patient information and demographics. The managed care organizations' report will categorize data to support federal reporting requirements on health care disparities. External evaluators will support the state with analyzing cross-sectional data over periods of time among comparison groups. Comparison groups will be matched by key individual characteristics (demographics, diagnoses, utilization rates) and geographic location (e.g., urban vs. rural residence). Claims and encounter data from Medicaid Management Information System (MMIS). The independent evaluator will support the data filtering and provide statistical reports on an agreed timeframe.

[3] State of New Mexico Governor's Commission on Disability

Strategy 2: As part of the Turquoise Care Medicaid Managed Care Contract (Effective July1,2024) HCA is requiring each managed care organization to obtain a National Committee for Quality Assurance Distinction in Multicultural Health Care/ Health Equity Accreditation. Details are outline at the link shared in Section 3 of the contract – Administrative Requirements/Requirements Prior to Operation. Turquoise Care MCOs Contracts - New Mexico Health Care Authority (nm.gov)

Strategy 3: VBP Strategy
New Mexico is enhancing provider networks to expand payment reform through value-based purchasing (VBP) arrangements. This strategy aims to reduce disparities in healthcare treatment and reimburse providers based on the quality and value of care. New Mexico Health Care Authority prioritizes reducing health disparities by developing standards for value-based purchasing arrangements. The value-based purchasing arrangement and methodology is outlined starting on page 435 in Turquoise Care MCOs Contracts - New Mexico Health Care Authority (nm.gov)

Monitoring and Compliance

New Mexico Health Care Authority monitors provider access and network adequacy in a variety of ways and through various reports.

Strategies for assessing managed care organizations:

- Provider Satisfaction Survey;
- Member Satisfaction Survey;
- Secret Shopper Survey;
- Managed Care Organizations' Call Center Reports;
- Member Grievances & Appeals Report;
- Primary Care Physician/ Primary Care Provider (PCP) Report;
- Pharmacy Monitoring Program and Pharmacy Prescriber Feedback Report;
- Geo/Access Report;
- Ad Hoc Managed Care Organizations' Number Reports;
- Quarterly and annual performance measure (PM) monitoring;
- Quarterly and annual tracking measure monitoring;
- Quarterly and annual hospital quality measure monitoring;
- Annual Consumer Assessment of Healthcare Providers and Systems (CAHPS);
- Annual Healthcare Effectiveness Data and Information Set (HEDIS);
- Audited Managed Care Organizations' Reports for Population Health and HCBS assurances;

- Annual External Quality Review Organization (EQRO) Reviews and Validations
    - Annual Performance Improvement Project (PIP) validation;
    - Annual Performance Measure (PM) validation;
    - Annual Compliance Review; and
    - Annual Network Adequacy validation

Network Adequacy and Availability of Services

New Mexico ensures the delivery of all covered benefits to all Medicaid members in a culturally competent manner and require that each managed care organization coordinate health care services and maintain a provider network sufficient to provide timely access to covered services for all its members.

The managed care organizations are required to have written policies and procedures that align with the Provider Network Standards detailed in the contract and the policy manual. The policies and procedures must describe how access to services will be available including prior authorization and referral requirements for medical and surgical services; emergency room services; behavioral health services; and long-term care services and support (LTSS).

Title 42 Code of Federal Regulations Section 438.68 network adequacy standards require states that contract with a managed care organization to develop and enforce time and distance standards for the following provider types: adult and pediatric primary care, obstetrics/gynecology, adult and pediatric behavioral health (for mental health and substance use disorder), adult and pediatric specialists, hospitals, pediatric dentists, and long-term services and support.

The managed care organizations are required to establish a mechanism to monitor adherence with Provider Network standards and submit a Network Adequacy Report to ensure compliance with the following:

Access Standards:

- Member caseload of any primary care provider should not exceed two thousand (1,500); and Members have adequate access to specialty providers.

Distance Requirements for primary care providers (including internal medicine, general practice, and family practice types), and pharmacies:

- Ninety percent (90%) of Urban members shall travel no farther than thirty (30) miles;
- Ninety percent (90%) of Rural members shall travel no farther than forty-five (45) miles;
- Ninety percent (90%) of Frontier members shall travel no farther than sixty (60) miles.

Distance Requirements for Behavioral Health Providers practitioners and Specialty Providers:

- Ninety Percent (90%) of Urban members shall travel no farther than thirty (30) miles.

- Ninety Percent (90%) of Rural members shall travel no farther than sixty (60) miles, unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted as approved by New Mexico Health Care Authority; and

- Ninety Percent (90%) of Frontier members shall travel no farther than ninety (90) miles, unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted as approved by New Mexico Health Care Authority.

Medical Assistance Division (MAD) has developed and made available on the Conduent New Mexico Medicaid Web Portal https://nmmedicaid.portal.conduent.com/webportal/providerSearch a lookup tool to help providers obtain the NPI of a rendering, prescribing, ordering, referring, or a ending provider. Providers will use this tool to determine if any services they are providing to Medicaid recipients are based on prescriptions, orders, or referrals from a provider who is not enrolled in the Medicaid or managed care program.

Evidence-Based Clinical Practices

The standards for quality management and quality improvement are outlined in New Mexico Health Care Authority's Turquoise Care contract with managed care organizations.

https://www.hca.nm.gov/ Turquoise Care MCOs Contracts Managed care organizations are required to establish and implement data driven quality management and quality improvement programs that align with the state's continuous improvement model.

The state's contract with the managed care organizations highlights the requirement for the managed care organizations to implement Mental Health Statistics Improvement Program (MHSIP), a clinician-rated systems survey instrument to measure consumer satisfaction.

Within the scope of the performance intervention projects (PIPS), managed care organizations are required to report any clinical-based interventions. Practice Guidelines are outlined in the contracts.

The guidelines for the evidence-based early childhood Medicaid Home-Visiting (MHV) service delivery model are outlined in the contracts.

Furthermore, the Turquoise Care Policy Manual provides guidance for pharmacy benefits, Preferred Drug List (PDL) and formulary requirements, treatment guidance for chronic hepatitis C virus, human immunodeficiency virus, medical aid in dying and the delivery of necessary diabetic resources. https://www.hca.nm.gov/providers/managed-care-policy-manual/

Directed Payments

After the Center's for Medicare and Medicaid approves the proposed state-directed payments, New Mexico Health Care Authority will use directed payment arrangements to direct specific payments. made by the managed care organizations to their participating providers. The managed care organizations will utilize outcome-based performance measures to evaluate the payment arrangement and assess the impact on improving access and quality and health outcomes for Medicaid beneficiaries.

The New Mexico Health Care Authority strives to select quality metrics that align with the department's mission and goals to assure that Medicaid members in the program receive the right amount of care, delivered at the right time, and in the right setting, and ensure that the care and services being provided are measured in terms of their quality and not solely by quantity.

The Turquoise Care Directed Payments are listed below:

- Community Tribal Hospitals – Uniform percentage increase established by the state for inpatient and outpatient services provided by practice plans under contract to community hospitals that serve a disproportionate share of Native American enrollees.

- Healthcare Quality Surcharge – Value-based purchasing and uniform percent increase arrangement established by the state to increase nursing facility per diem rates by the market basket index (MBI) factor and to provide quality incentive payments for nursing facilities under contract that meet performance requirements on specified quality metrics.

- Nursing Facility Value Based Purchasing – Value-based purchasing and uniform percent increase arrangement established by the state to increase to nursing facility per diem rates for the Market Basked Index (MBI) factor and to provide quality incentive payments for nursing facilities under contract that meet performance requirements on specific quality metrics.

- UNM Hospitals – Uniform increase for inpatient and outpatient hospital services and performance-based quality payments established by the state for hospitals that provide guaranteed access to care for Native Americans through the Indian Health Services.

- UNM Medical Group – Uniform percentage increase established by the state for qualified practitioners who are members of a practice plan under contract to provide professional services at a state-owned academic medical center.

- Ambulance Supplemental Payment Program (ASPP) IGT – Applicable to eligible governmental ground ambulance transportation providers for the purpose of improving access to quality healthcare for all Medicaid members.

- Healthcare Delivery Access Act (HDAA) - Uniform percentage increase and quality incentive payment established by the state for inpatient and outpatient hospital services provided by Safety Net Care Pool hospital providers.

- Primary Care Payment Reform VBP – To increase compensation for primary care clinicians and practices to improve access to primary care services for patients, to increase health equity, manage healthcare costs carefully to ensure that the system is sustainable.

- Non-Contract Providers Minimum Fee Schedule - The preprint is to incentivize Non-Contract Providers to contract with MCOs and maintain access to care for Turquoise Care program members.

Non-Compliance Sanctions and Penalties

The New Mexico Health Care Authority established standards for sanctions and penalties for failure to meet agreement requirements. This applies to all managed care organizations, affiliate, parent or subcontractor, and to any party that fails to comply with the contract. New Mexico Health Care Authority may impose non-monetary sanctions and/or monetary penalties. If the state determines the managed care organizations acted or failed to act in adherence with the contractual requirements then the managed care organizations and their affiliates could be subject to the following:

- Corrective Action Plans
- Sanctions
    - Non-Monetary Sanctions
    - Monetary penalties
    - Non-Monetary Intermediate Sanctions
- Termination of the Managed Care Organization Agreement
- Civil Monetary Penalties
- Other Monetary penalties

The following table describes the penalties outlined in the Turquoise Care Managed Care Organization's Contract:

PROGRAM ISSUES	PENALTY
1. Failure to comply with Claims processing as described in Section 4.20 of the contract	Up to two percent (2%) of the MCO's monthly Capitation Payment for each month that HCA determines that the MCO is not in compliance with the requirements of Section 4.20 of the contract HCA will determine the specific percentage of the capitation penalty based on the severity or frequency of the infraction.
2. Failure to comply with the requirements for arranging for a Member to receive care out-of-state as described in Sections 4.4.16.8, 4.8.1.5.2.3.1, and 4.8.5.3 of the contract	Up to two percent (2%) of the MCO's monthly Capitation Payment for each month that HCA determines that the MCO is not in compliance with the requirements of Sections 4.4.16.8, 4.8.1.5.2.3.1, and 4.8.5.3. of the contract HCA will determine the specific percentage of the capitation penalty based on the severity or frequency of the infraction.
3. Failure to make directed payments on a timely basis as described in Attachment 10: Directed Payments of the contract	Up to two percent (2%) of the MCO's monthly Capitation Payment for each month that HCA determines that the MCO is not in compliance with the requirements: Directed Payments of the contract HCA will determine the specific

PROGRAM ISSUES	PENALTY
	percentage of the capitation penalty based on the severity
4. Failure to comply with Encounter Submission, including failure to comply with 837 PACDR upon implementation of MMIS-R, as described in Section 4.20of the contract	Up to two percent (2%) of the MCO's monthly Capitation Payment for each quarter in which the penalty is assessed. HCA will determine the specific percentage of the capitation penalty based on the severity or frequency of the infraction.
5. Failure to assign a Member to the required Care Coordination Level (CCL0, CCL1, or CCL2) as described in Section 4.4 of the contract	One thousand dollars ($1,000) per Member for which the MCO fails to assign the Member to the required CCL.
6. Failure to comply with the time frames for a CNA for Care Coordination Level one (1) and Level two (2) as described in Section 4.4 of the contract	One thousand dollars ($1,000) per Member for which the MCO fails to comply with the time frames for that Member.
7. Failure to comply with Personnel Requirements as described in Sections 3.3 of the contract	One thousand dollars ($1,000) per Calendar Day per position.
8. Failure to meet performance standards for the Member services line, Provider services call center line, nurse triage/nurse advice line, and the UM line as described in Sections 4.11 and 4.16 of the contract	Up to five percent (5%) of the MCO's monthly Capitation Payment for each month in which the penalty is assessed. HCA will determine the specific percentage of the capitation penalty based on the severity or frequency of the infraction.
9. Failure to meet General Non-Emergency Medical Transportation (NEMT) minimum standards for Members to access appointments. This excludes critical care NEMT.	Up to five percent (5%) of the MCO's monthly Capitation Payment for each month in which the penalty is assessed. HCA will determine the specific percentage of the capitation penalty, taking into consideration factors reasonably related to the nature and severity of the infraction.
10. Failure to comply with Member transition of care requirements as described in Section 4.4 of the contract	Five thousand dollars ($5,000) per Member in which the MCO fails to comply with the transition of care requirements for that Member.
11. Failure to meet appointment standards as described in Section 4.8 of the contract	Up to two percent (2.0%) of the MCO's monthly Capitation Payment for each month in which the penalty is assessed. HCA will determine the specific percentage of the capitation penalty, taking into consideration factors reasonably related to the nature and severity of the infraction.
12. Failure to complete or comply with CAPs/DCAPs.	Up to two percent (2.0%) of the MCO's monthly Capitation Payment per Calendar Day for each day the CAP is not completed or complied with as required. Up to five percent (5.0%) of the MCO's monthly Capitation Payment per Calendar Day for each day the DCAP is not completed or complied with as required. HCA will determine the specific

PROGRAM ISSUES	PENALTY
	percentage of the capitation penalty based on the severity or frequency of the infraction.
13. Failure to obtain approval of Member Materials as required by Section 4.15.1 of the contract.	Five thousand dollars ($5,000) per day for each Calendar Day that HCA determines the MCO has distributed Member Material that has not been approved by HCA. The five thousand dollars ($5,000) per day damage amounts will double every ten (10) Calendar Days.
14. Failure to comply with the time frame for responding to Grievances and Appeals required in Section 4.17 of the contract	One thousand dollars ($1,000) per occurrence in which the MCO fails to comply with the time frames.
15. For every report that meets the definition for "Failure to Report" in accordance with Section 4.22 of the contract	Five thousand dollars ($5,000) per report, per occurrence. With the exception of the cure period: One thousand dollars ($1,000) per report, per Calendar Day. The one thousand dollars ($1,000) per day damage amounts will double every ten (10) Calendar Days.
16. Failure to submit timely Summary of Evidence in accordance with Section 4.17 of the contract	Five thousand dollars ($5,000) per occurrence.
17. Failure to have legal counsel appear in accordance with Section 4.17 of the contract	Ten thousand dollars ($10,000) per occurrence.
18. Failure to meet targets for the PMs.	Three (3.0%) of the total capitation paid to the MCO for the Agreement year, divided by the number of PMs specified in the Agreement year.
19. Failure to meet DSIPTs as described in Section 6.9 of the contract: Delivery System Improvement Performance Targets (DSIPTs) of the contract	Two percent (2.0%) of Capitation Payments as specified in Section 6.9 of the contract, for failure to meet a DSIPT.
20. Failure to pay Contract and Non-Contract Providers rates that comply with State Minimum Wage Requirements.	Up to five percent (5.0%) of the MCO's monthly Capitation Payment for each month in which the penalty is assessed. HCA will determine the specific percentage of the capitation penalty, taking into consideration factors reasonably related to the nature and severity of the infraction.
21. HCA can modify and assess any monetary penalty if the MCO engages in a pattern of behavior that constitutes a violation of this Agreement or may potentially involve a risk of harm to Members or to the integrity of Turquoise Care. This may include, but is not limited to the following: Reporting metrics not met; failure to complete Care Coordination activities by the time frames specified within this Agreement; failure to report on required data elements in report submissions; for a report that has been rejected by and resubmitted by the MCO up to three (3) times	Up to five percent (5.0%) of the MCO's monthly Capitation Payment for each month in which the penalty is assessed. HCA will determine the specific percentage of the capitation penalty, taking into consideration factors reasonably related to the nature and severity of the infraction.

PROGRAM ISSUES	PENALTY
and the report still meets the definition of for "Failure to Report" in accordance with Section 4.22 of the contract	

Abbreviations used in the table: HCA- Health Care Authority, PMs- Performance Measures, DSIPT- for Delivery System Improvement Performance Targets, TMs-Tracking Measures, MCO-Managed Care Organization, CCL-Care Coordination Level, CAP-Corrective Action Plan, DCAP-Directed Corrective Action Plan, NEMT- Non-Emergency Medical Transportation, UM-Utilization Management, CCP-Comprehensive Care Plan, and CNA- Comprehensive Needs Assessment.

External Quality Review and Evaluation

In accordance with 42 CFR 438.354, New Mexico Health Care Authority has retained the services of an External Quality Review Organization (EQRO), Island Peer Review Organization, to perform External Quality Reviews (EQRs). The external quality review organization will conduct all mandatory external quality review activities to assess quality outcomes and timeliness of, and access to, the services provided to Medicaid members and covered by each managed care organization.

The external quality review organization will follow the Centers for Medicare and Medicaid protocols for the following activities:

- Validation of Performance Improvement Projects; an annual review designed to verify the projects developed by the managed care organization were designed, conducted and reported in a methodically sound manner and address the target population defined by New Mexico Health Care Authority;
- Validation of Performance Measures; an annual review designed to evaluate the accuracy of New Mexico Health Care Authority's established performance measures reported by the managed care organizations;
- Compliance Monitoring: an annual review designed to determine the managed care organizations compliance with state and federal Medicaid regulations and applicable elements of the contract between the managed care organization and New Mexico Health Care Authority;
- Validation of Network Adequacy; an annual review designed to determine the managed care organizations' compliance with state and federal Medicaid regulations and applicable elements of the contract between the managed care organization and New Mexico Health Care Authority; and
- Technical Report; an annual report summarizing the findings on access and quality of care.

The managed care organizations are required to cooperate fully with the external quality review organization and demonstrate compliance with New Mexico's managed care regulations and quality standards as set forth in federal regulation and state policy. The external quality review organization reports findings and recommendations to New Mexico Health Care Authority. As deemed appropriate the findings and recommendation maybe incorporated into New Mexico's Quality Strategy.

Non-duplication of EQR Activities

The New Mexico Health Care Authority does not exercise the non-duplication option. New Mexico Health Care Authority does not use information from Medicare or accreditation reviews to conduct annual external quality reviews. All required external quality review activities including the mandatory annual reviews and validations are conducted by The New Mexico Health Care Authority, or it's contracted external quality review organization.

The New Mexico Health Care Authority has a designated contract administrator authorized to represent New Mexico Health Care Authority in all matters related to external quality review. The contract administrator monitors the scope of work for the external quality review organization. Separate activities performed within New Mexico Health Care Authority and the Medical Assistance Division ensures non-duplication of external quality review activities.

Public and Tribal Comment

The New Mexico Quality Strategy will be published on the New Mexico Health Care Authority website for thirty (30) days to allow all interested parties to provide feedback and public comment. The comments and feedback are considered and/or incorporated into the Quality Strategy as deemed applicable to the goals and objectives established by New Mexico Health Care Authority.

The Health Care Authority solicited input and recommendations regarding content and direction of the Quality Strategy from a variety of sources including:

- Medicaid members
- The public
- Stakeholders
- Medicaid Advisory Committee
- Tribal Leadership, Indian Health Services, Tribal Health Providers
- Managed Care Organizations
- External Quality Review Organization (EQRO)
- Behavioral Health Collaborative

Home and Community-Based Services Waiver Assurances: Quality Strategy for 1915(c) and 1915(i) Waiver Programs

The purpose of the Home and Community-Based Services 1115 Demonstration Quality Strategy for both 1915i-like and 1915c-like programs is to locate areas that warrant improvements within the programs by monitoring performance measures in the following areas:

- Service Plans
- Nursing Facility Level of Care (NF LOC) Eligibility Determinations
- Provider Requirements
- Administrative Authority
- Financial Responsibility
- Critical Incidents

New Mexico Health Care Authority's process includes ensuring managed care organizations collect and maintain the appropriate data and report to the Health Care Authority in a timely manner. The state compiles data through various methodologies. The set target rate for the home and community-based services performance measures is 86%. The results of these data collection methods and analysis will be

reported in the Annual Report to the Centers for Medicare and Medicaid or through a separate report at the end of each demonstration year.

The remainder of this report includes details of 1915c-like Waiver Assurances for Home Community-Based Services and Pre-Tenancy and Tenancy Program (1915i-like) that will be monitored, assessed, and reported on throughout the waiver period.

Section 1115 Demonstration Performance Measures for 1915(c)-like Home and Community-Based Services (HCBS)

A. Administrative Authority

The State Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the demonstration program by exercising oversight of the performance of functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

- Percent of required Home Community-Based Services reports submitted timely by the managed care organizations.
- Percent of required Home Community-Based Services reports submitted accurately without a managed care organization self-identified error.
- Percent of required Home Community-Based Services reports submitted accurately without a rejection.

The target for each measure is 86%. The Health Care Authority monitors quarterly and reports to the Centers for Medicare and Medicaid annually.

B. Level of Care

Sub-Assurance B-i: Applicants with reasonable likelihood of needing services receive a level of care determination and the benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved program.

- The total number of re-evaluated members for Nursing Facility Level of Care. The target for this measure is 86%. The Health Care Authority monitors quarterly and reports to the Centers for Medicare and Medicaid annually.

Sub-Assurance B-iii: The process and instruments described in the approved demonstration are applied appropriately and according to the approved description to determine participant level of care.

- The number of Nursing Facility Level of Care members who met the criteria of the Health Care Authority established Nursing Facility Level of Care eligibility criteria instructions. The target for this measure is 86%. The Health Care Authority monitors quarterly and reports to the Centers for Medicare and Medicaid annually.

C. Qualified Providers

Sub-Assurance C-i: The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other state standards prior to their furnishing services.

- Number and percent of enrolled licensed/certified providers who meet licensure /certification requirements prior to furnishing waiver services. The target for this measure is 86%. The Health Care Authority monitors quarterly and reports to the Centers for Medicare and Medicaid annually.

*Sub-Assurance C-ii**:** The state monitors non-licensed/non-certified providers to assure adherence to demonstration requirements.*

- Number and percent of enrolled non-licensed/non-certified providers who meet licensure /certification requirements prior to furnishing waiver services. The target for this measure is 86%. The Health Care Authority monitors quarterly and reports to the Centers for Medicare and Medicaid annually.

Sub-Assurance C-iii: The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved demonstration.

- Number and percent of provider training programs convened by the managed care organization in accordance with the managed care organization's annual training plans and contractual requirements. The target for this measure is 86%. The Health Care Authority monitors quarterly and reports to the Centers for Medicare and Medicaid annually.

D. Service Plans

Sub-Assurance D-i: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by provision of services or through other means.

- Number and percent of comprehensive care plans that address all needs and personal goals. The target for this measure is 86%. The Health Care Authority monitors quarterly and reports to the Centers for Medicare and Medicaid annually.

Sub-Assurance D-iii: Service plans are updated/revised at least annually or when warranted by changes in individual needs.

- Total number of files of Home Community-Based Service plans that were revised as needed to address changing needs. The target for this measure is 86%. The Health Care Authority monitors quarterly and reports to the Centers for Medicare and Medicaid annually.

Sub-Assurance D-iv: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.

- Number and percent of comprehensive care plans where services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the CCP. The target for this measure is 86%. The Health Care Authority monitors quarterly and reports to the Centers for Medicare and Medicaid annually.

Sub-Assurance D-v: Participants are afforded choice between demonstration services and institutional care; and between/among demonstration services and providers.

- Number and Percent of comprehensive care plans that clearly document that the member was afforded a choice of waiver services and providers. The target for this measure is 86%. The

Health Care Authority monitors quarterly and reports to the Centers for Medicare and Medicaid annually.

G. Health and Welfare of Enrollees

Sub-Assurance G-i: The state, on an ongoing basis, identifies, address, and seeks to prevent the occurrence of abuse, neglect, exploitation and unexplained death.

- Number of critical incidents by reporting category (abuse, neglect, exploitation, environmental hazard, emergency services, law enforcement, elopement/missing, and death). The target for this measure is 86%. The Health Care Authority monitors quarterly and reports to the Centers for Medicare and Medicaid annually.

Sub-Assurance G-ii: The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further incidents to the extent possible

- The percentage of follow-up actions taken on the substantiated Critical Incidents on a systemic basis to prevent future incidents, such as investigation as well as educating individuals and families. The target for this measure is 86%. The Health Care Authority monitors quarterly and reports to the Centers for Medicare and Medicaid annually.

- The percentage of substantiated individual Critical Incidents where follow up (safety plans, corrective action plans, etc.) was completed. The target for this measure is 86%. The Health Care Authority monitors quarterly and reports to the Centers for Medicare and Medicaid annually.

Sub-Assurance G-iii: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

- The percentage of providers and managed care organization's staff educated about reporting Critical Incidents to the Health Care Authority Critical Incident Reporting Portal initially at the start or at hire, and at least annually thereafter. The target for this measure is 86%. The Health Care Authority monitors quarterly and reports to the Centers for Medicare and Medicaid annually.

Sub-Assurance G-iv: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved demonstration.

- The percentage of substantiated Critical Incidents reported by category. The target for this measure is 86%. The Health Care Authority monitors quarterly and reports to the Centers for Medicare and Medicaid annually.

- The percentage of substantiated Critical Incidents being reported within the required time frame. The target for this measure is 86%. The Health Care Authority monitors quarterly and reports to the Centers for Medicare and Medicaid annually.

*The Health Care Authority utilizes a Critical Incidents Management System to report instances of abuse, neglect, exploitation and unexplained deaths are reported by the managed care organizations and providers into the web based the Health Care Authority's Critical Incident Reporting (CIR) Portal.

I. Financial Accountability

Sub-Assurance I-i: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved demonstration and only for services rendered.

Sub-Assurance I-ii: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five-year demonstration cycle.

- Number and percent of managed care organization contract annual rating periods with documented actuarially sound capitation rates.

Section 1115 Demonstration Performance Measures for 1915(i)-like Home and Community-Based Services (HCBS)

A. Pre-Tenancy/Tenancy Service Plans:

Requirement 1: Service plans a) address assessed needs of 1915(i)-like participants

- Total number of members who received (having an active service plan) Pre-Tenancy and Tenancy services annually, monitored by the Health Care Authority-Behavioral Health Services Division.

*Sub-requirement 1-b**:** Service plans are updated annually.*

- Total number of participants were projected to be served and how may were served—annually, monitored by the Health Care Authority-Behavioral Health Services Division.

Sub-requirement 1-c: Service plans document the 1915(i)-like participant's choice of services and providers.

- Total number of members who received education about tenant's responsibilities and rights annually, monitored by the Health Care Authority -Behavioral Health Services Division.

B. Pre-Tenancy/Tenancy Eligibility Requirements:

Requirement 2: Eligibility Requirements

Sub-requirement 2-a: An evaluation for 1915(i)-like Home Community-Based Services eligibility is provided to all applicants for whom there is reasonable indication that 1915(i)-like services may be needed in the future.

- Total number of vouchers issued to participants. The Health Care Authority -Behavioral Health Services Division monitors quarterly.

Sub-requirement 2-b: The processes and instruments described in the approved demonstration for determining 1915(i)-like eligibility are applied appropriately.

- Number of eligible members who met the needs-based criteria monitored quarterly through managed care organizations and the Health Care Authority -Behavioral Health Services Division.

Sub-requirement 2-c: The 1915(i)-like benefit eligibility of enrolled individuals is reevaluated at least annually or, if more frequent, as specified in the approved demonstration.

- Number of recertifications for supportive housing eligibility monitored annually by the Health Care Authority -Behavioral Health Services Division.

C. Pre-Tenancy/Tenancy Provider Requirements:

Requirement 3: Provider Requirements

- Number of providers that met application requirements reviewed tri-annually by the Health Care Authority -Behavioral Health Services Division.

D. Pre-Tenancy/Tenancy Setting Requirements:

Requirement 4: Settings meet the home and community-based setting requirements as specified in the approved demonstration and in accordance with 42 CFR 441.710(a)(1) and (2).

- Total numbers of housing units that passed the 'Housing Quality Standards' inspections annually monitored by the Health Care Authority -Behavioral Health Services Division.

E. Pre-Tenancy/Tenancy Authority Requirements:

Requirement 5: The SMA retains authority and responsibility for program operations and oversight.

- Total number of paid encounters to providers billing H0043 and H0044, including unduplicated totals reported quarterly and monitored by the Health Care Authority - Behavioral Health Services Division.

F. Pre-Tenancy/Tenancy Financial Accountability Requirements:

Requirement 6: The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i)-like participants by qualified providers

- Total costs by region and county by quarter monitored by the Health Care Authority - Behavioral Health Services Division.

G. Pre-Tenancy/Tenancy Health and Wellness Requirements:

Requirement 7: The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

- The number of crisis plans that are updated by providers. The Health Care Authority - Behavioral Health Services Division monitors and reviews annually.