



NEW MEXICO  
MEDICAID  
MANAGED CARE PROGRAM  
QUALITY STRATEGY

October 2023 Revision

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## **Section I: Introduction:**

### **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 healthcare services in New Mexico. Optum Health, was selected as the Statewide Entity charged with the oversight of behavioral healthcare services for Medicaid recipients in Salud!.

On March 18, 2005, 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 (MCOs). The primary goal of the program was to mitigate the array of problems resulting from the fragmentation of services provided to Medicare and Medicaid dual 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 a FFS program. Seventy percent of the Medicaid enrollees were in a managed care setting. Seven different health plans administered the various delivery systems. Services were provided under an umbrella of programs for eligible individuals in more than 40 eligibility categories.

In 2014, New Mexico embarked on a new path to deliver integrated care to the Medicaid population through a Section 1115 Demonstration Waiver known as Centennial Care. The 1115 Demonstration Waiver consolidated all previous federal waivers, with the exception of the 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 MCO 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, HSD contracted with four MCOs 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. HSD require the MCOs to work with providers to implement patient centered medical homes (PCMHs) resulting in an increase in members participating in a PCMH with over 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. Approval of this demonstration amendment will enable New Mexico to receive federal financial participation (FFP) once CMS approves 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 will also provide FFP for improvements to New Mexico's Home and Community Based Services (HCBS), as well as for the implementation of a High-Fidelity Wraparound (HFW) intensive care coordination benefit.

With the implementation of Centennial Care 2.0, New Mexico continues advancing successful initiatives under the demonstration continuing to implement new, targeted initiatives to address specific gaps in care and improve healthcare outcomes for Centennial Care Members. Key initiatives under the Centennial Care 2.0 program include:

- 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; and
- Further simplifying administrative complexities and implement refinements to program and benefit design.
- Expand the Medicaid program toward a more integrated model of behavioral health care delivery by providing Medicaid reimbursement for extended IMD stays for individuals with Serious Mental Illness/Severe Emotional Disease

## **Section II: New Mexico Managed Care Quality Strategy**

[CMS requirement CFR §438.340\(a\)](#)

**General rule.** Each State contracting with a Managed Care Organization (MCO) must draft and implement a written quality strategy for assessing and improving the quality of healthcare and services furnished by the MCO.

### **Network Adequacy and Availability**

CMS requirement CFR §438.340(b)(1)

Elements of the State quality strategy. At a minimum, the State's quality strategy must include the following: The State-defined network adequacy and availability of services standards for MCOs required by §§438.68 and 438.206 and examples of evidenced-based clinical practice guidelines the State requires in accordance with §438.236.

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

The MCOs are required to have written policies and procedures that align with the Provider Network standards detailed in the MCO contract and the Centennial Care policy manual. The policies and procedures must describe how access to services will be available including prior authorization and referral requirements for medical and surgical services; emergency room services; behavioral health services; and long-term care services.

The MCOs 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 (PCP) should not exceed two-thousand (2,000); and
  - Members have adequate access to specialty providers.
- Distance Requirements for PCPs (including internal medicine, general practice, and family practice types), and pharmacies:
  - Ninety percent (90%) of Urban members shall travel no farther than thirty (30) miles;
  - Ninety percent (90%) of Rural members shall travel no farther than forty-five (45) miles; and
  - 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 HSD; 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 HSD.
- Timeliness requirements:
  - No more than thirty (30) calendar days, for routine, asymptomatic, member-initiated, outpatient appointments for primary medical care;

- No more than sixty (60) calendar days, for routine, asymptomatic member-initiated dental appointments;
- No more than fourteen (14) calendar days for routine, symptomatic member-initiated, outpatient appointments for non-urgent primary medical, behavioral health and dental care;
- Within twenty-four (24) hours for primary medical, behavioral health and dental care outpatient appointments for urgent conditions;
- Consistent with clinical urgency but no more than twenty-one (21) calendar days for specialty outpatient referral and consultation appointments, excluding behavioral health;
- Consistent with clinical urgency but no more than fourteen (14) calendar days for routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments;
- Consistent with the severity of the clinical need, walk-in rather than an appointment, for outpatient diagnostic laboratory, diagnostic imaging and other testing;
- Consistent with clinical urgency, but no longer than forty-eight (48) hours for urgent outpatient diagnostic laboratory, diagnostic imaging and other testing;
- No longer than forty (40) minutes for the in-person prescription fill time (ready for pickup). A prescription called in by a practitioner shall be filled within ninety (90) minutes;
- Consistent with clinical needs for scheduled follow-up outpatient visits with practitioners; and
- Within two (2) hours for face-to-face behavioral health crisis services.

The MCOs are required to have the appropriate licenses in the state to do risk-based contracting through a managed care network of health care providers. The MCOs are also required to employ a full-time staff person responsible for provider services and provider relations, including all network management issues, provider payment issues and provider education.

The MCOs are required to develop written policies and procedures that meet NCQA standards and state and federal regulations for credentialing and re-credentialing of contracted providers. The policies and procedures should include but are not be limited to: defining the scope of providers covered; the criteria and the primary source verification of information used to meet the criteria; the process used to make decisions that shall not be discriminatory; and the extent of delegated credentialing and re-credentialing arrangements.

The MCOs' network providers are obligated to abide by all federal, state and local laws, rules and regulations, including but not limited to those laws, regulation, and rules applicable to providers of services under Title XIX (Medicaid) of the Social Security Act and other health care programs administered by New Mexico.

All health care providers rendering services to Medicaid members are required to render covered services to eligible recipients in the same scope, quality, and manner as provided to the general public; comply with all federal and state civil rights laws; and not discriminate on the basis of



race, color, national origin, sex, gender, age, ethnicity, religion, sexual orientation, sexual preference, health status, disability, political belief or source of payment.

Evidenced-Based Clinical Practice Guideline (CPGs) from the MCOs include examples from their Quality Management and Quality Improvement (QM/QI) plan such as Asthma, Diabetes, ADHD (Attention Deficit Hyperactive Disorder)/ADD (Attention Deficit Disorder), Depression, and Obesity. CPGs are required to be updated every two years and analyzed for relevant member population and practitioner/specialists and disseminated to providers.

### **Continuous Quality Improvement**

CMS requirement CFR §438.340(b)(2)

**Elements of the State quality strategy. At a minimum, the State's quality strategy must include the following: The State's goals and objectives for continuous quality improvement which must be measurable and take into consideration the health status of all populations in the State served by the MCO.**

### **Centennial Care Goals and Objectives**

The New Mexico Human Services Departments Mission is to transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

The State's goals for Centennial Care 2.0 are to build upon the program's accomplishments to include providing the most effective and efficient health care possible for eligible New Mexicans, as well as continuing the healthcare delivery reforms of Centennial Care. Specifically, the state will further the following:

- Assure that Medicaid Members in the program receive the right amount of care, delivered at the right time, and in the right setting;
- Ensure that the care and services being provided are measured in terms of their quality and not solely by quantity;
- Slow the growth rate of costs or "bend the cost curve" over time without inappropriate reductions in benefits, eligibility or provider rates; and streamline and modernize the Medicaid program in the state;
- Provide an integrated, comprehensive Medicaid delivery system in which a member's Managed Care Organization (MCO) is responsible for coordinating his/her full array of services, including acute care (including pharmacy) behavioral health services, institutional services and home and community -based services.

The State's objectives for Centennial Care 2.0 will track the progress towards achieving the stated goals as well as identify opportunities for improvement by applying measurable and relevant activities that focus on monitoring and assessing member outcomes, MCOs performance and compliance, and member satisfaction by conducting the following:

- 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); and
- 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.

New Mexico's Quality Strategy utilizes a Continuous Quality Improvement (CQI) model to achieve goals and objectives outlined for the Centennial Care program. HSD, through the QM/QI standards, requires the MCOs to apply the CQI model and identify opportunities for measurable improvement taking into consideration the health status of all populations served by the MCOs. New Mexico conducts an annual review of each MCO's QM/QI program that includes a Work Plan and Evaluation by an integrated team from the MAD and Behavioral Health Services Division (BHSD). New Mexico requires MCOs to comply with state and federal standards for QM/QI and adhere to the following:

- Establish a QM/QI program based on a model of continuous quality improvement using clinically sound, nationally developed and accepted criteria;
- Recognize the opportunities for improvement are unlimited;
- Ensure the QM/QI process is data driven, requiring continual measurement of clinical and non-clinical processes driven by such measurements;
- Require re-measurement of effectiveness and continuing development and implementation of improvements as appropriate;
- Reflect member and contracted provider input;
- Develop a QM/QI annual program description that includes goals, objectives, structure, policies and procedures that result in continuous quality improvement;
- Review outcome data at least quarterly for performance improvement, recommendations and interventions;
- Establish a mechanism to detect under and over utilization of services;
- Have access to, and the ability to collect, manage and report to HSD data necessary to support the QM/QI activities;
- Establish a committee to oversee and implement all policies and procedures;
- Ensure that the ultimate responsibility for QM/QI is with the MCO and shall not be delegated to subcontractors;

- Develop an annual QM/QI work plan to be submitted at the beginning of each year and include, at a minimum, immediate objectives for each year and long-term objectives for the entire term of the contract;
- Implement Performance Improvement Projects (PIPs) identified internally by the MCO and as directed by HSD;
- Design sound quality studies, apply statistical analysis to data and derive meaning from the statistical analysis; and
- Submit an annual QM/QI written evaluation to HSD that includes, but is not limited to:
  - A description of ongoing and completed QM/QI activities;
  - Inclusion of measures that are trended to assess performance;
  - Findings that incorporate prior year information and contain an analysis of any demonstrable improvements in the quality of clinical care and service;
  - Development of future work plans based on the incorporation of previous year findings of overall effectiveness of QM/QI program;
  - Demonstration that active processes are implemented that measure associated outcomes for assessing quality performance, identifying opportunities for improvement, initiating targeted quality interventions and regularly monitoring each intervention's effectiveness;
  - Demonstration that the results of QM/QI projects and reviews are incorporated into the QM/QI program;
  - Incorporation of annual HEDIS results in the following year's plan as applicable to HSD specific programs;
  - Communication with appropriate Contracted Providers about the results of QM/QI activities and opportunities for providers to review and use this information to improve their performance, including technical assistance, corrective action plans, and follow-up activities as necessary; and upon request, present behavioral health aspects of the MCOs' annual QM/QI work plan during the New Mexico Behavioral Health Collaborative quarterly meeting.

### **Utilization Management Standards**

HSD requires the MCOs to establish and implement a utilization management (UM) system that follows the National Committee for Quality Assurance (NCQA) UM standards and promotes quality of care, adherence to standards of care, efficient use of resources, member choice, and the identification of service gaps within the service system. The MCO UM system must:

- Ensure members receive services based on their current conditions and effectiveness of previous treatment;
- Ensure services are based on the history of the problem/illness, its context and desired outcomes;
- Assist members and/or their representatives in choosing among providers and available treatments and services;

- Emphasize relapse and crisis prevention, not just crisis intervention;
- Detect over and under utilization of services to assess quality and appropriateness of care furnished to members with special health care needs;
- Accept the uniform prior authorization form for prescription drug benefits and respond to prior authorization request within three (3) business days;
- Comply with state and federal requirements for Utilization Management, including but not limited to, 42 CFR 456 and §438.910 (d);
- Manage the use of limited resources and 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 HSD existing UM edits in the MCO's 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, etc.;
- Define and submit annually to HSD a written copy of the MCO's UM program description, UM work plan and UM evaluation, which shall include, but not limited to:
  - A description of the MCO's UM program structure and accountability mechanisms;
  - A description of how the UM work plan supports the goals within in the UM program and specific indicators that will be used for periodic performance tracking and trending as well as processes or mechanisms used for assessment and intervention. The UM work plan must be data driven with key indicators that are used to ensure that under-and-over utilization are detected by the MCO and addressed appropriately; and
  - A comprehensive UM program evaluation that includes an evaluation of the overall effectiveness of the UM program, an overview of UM activities and an assessment of the impact of the UM 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 UM work plan.
- Ensure the involvement of appropriate, knowledgeable, currently practicing practitioners in the development of UM procedures;
- Submit to HSD the proposed UM clinical criteria to be used for services requiring prior authorization;
- Upon request, the MCO shall provide UM decision criteria to providers, members, their families and the public;
- Define how UM decisions will be communicated to the member and the member's PCP or to the provider requesting the authorization;
- Comply with the most rigorous standards or applicable provisions of either NCQA, HSD regulation, 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 MCO’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 HSD-specified time frames;
- Develop and implement policies and procedures by which UM 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 PCPs 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 MCO shall provide for a review and periodic update of the course of treatment, according to best practices.

### **MCO Accreditation Standards**

New Mexico requires the MCOs be either (i) National Committee for Quality Assurance (NCQA) accredited in the state of New Mexico or (ii) accredited in another state where the MCO currently provides Medicaid services and achieves New Mexico NCQA accreditation by January 1, 2020.

Failure to meet the accreditation standards and/or failure to attain or maintain accreditation is considered a breach of the MCO contract with HSD. Violation, breach or noncompliance with the accreditation standards may be subject to termination for cause as detailed in the contract.

MCO accreditation status is reviewed annually by the EQRO and included in HSD’s annual technical report.

<https://www.hsd.state.nm.us/external-quality-review-organization-eqro-reports/>.

### **Quality Metrics and Performance Targets**

CMS requirement CFR §438.340(b)(3)(i)

Elements of the State quality strategy. At a minimum, the State’s quality strategy must include the following: A description of the quality metrics and performance targets to be used in measuring the performance and improvement of each MCO with which the State contracts, including but not limited to, the performance measures reported in accordance with §438.330

(c). The State must identify which quality measures and performance outcomes the State will publish at least annually on the State's web site required under §438.10(c)(3).

### **Centennial Care 2.0 Performance Measures**

New Mexico selects quality metrics and performance targets by assessing gaps in care within the State's Medicaid population. HSD monitors and utilizes data that evaluates the MCOs' strengths and opportunities for improvement in serving the Medicaid population by specifying Performance Measures (PMs). The selected PMs and performance targets are reasonable, based on industry standards, and consistent with CMS EQR Protocols. HSD conducts quarterly monitoring of the PMs to determine trending and to identify risks to meeting the specified performance targets. The information is shared with the MCOs during the quarterly quality meetings. PMs and performance targets are based on HEDIS technical specifications for the current reporting year. The MCO is required to follow relevant and current NCQA HEDIS standards for reporting. In addition, an annual validation of the PMs is conducted by New Mexico's EQRO and posted on the HSD website.

<https://www.hsd.state.nm.us/external-quality-review-organization-eqro-reports/>.

In 2019 New Mexico's PM targets required the MCOs to improve PM outcomes by either; a two (2) percentage point improvement above the MCO's NCQA audited HEDIS rates; or achievement of the Health and Human Services (HHS) Regional Average as determined by NCQA Quality Compass data. Failure to meet the established performance targets results in MCO monetary penalties. The Centennial Care 2.0 Calendar Year (CY) 2019 Performance Measures were as follows:

- PM #1–Well Child Visits in the First fifteen (15) Months of Life (W15). The percentage of members who turned fifteen (15) months old during the measurement year and had six (6) or more well-child visits;
- PM #2–Children and Adolescents' Access to Primary Care Practitioners (CAP). The percentage of members, twelve (12) months through nineteen (19) years of age, who had a visit with a PCP. Report four separate percentages for each age group: Twelve (12) through twenty-four (24) months of age, who had a visit with a PCP during the measurement year; twenty-five (25) months through six (6) years of age, who had a visit with a PCP during the measurement year; seven (7) through eleven (11) years of age, who had a visit with a PCP during the measurement year or the year prior to the measurement year; and twelve (12) through nineteen (19) years of age, who had a visit with a PCP during the measurement year or the year prior to the measurement year;
- PM #3–Adult BMI Assessment (ABA). The percentage of members eighteen (18) through seventy-four (74) years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year;
- PM #4–Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC). The percentage of members, three (3) through seventeen (17) years of age, who had an outpatient visit with a PCP or OB/GYN and who had evidence of the

following during the measurement year: BMI percentile documentation; Counseling for nutrition; and Counseling for physical activity;

- PM #5–Comprehensive Diabetes Care (CDC). The percentage of members, eighteen (18) through seventy-five (75) years of age, with diabetes (Type 1 or Type 2) who had each of the following during the measurement year: an HbA1c Test; HbA1c Poor Control, greater than 9%; a retinal eye exam; and a nephropathy screening test for kidney disease;
- PM #6–Prenatal and Postpartum Care (PPC). The percentage of member deliveries of live births between November 6 of the year prior to the measurement years and November 5 of the measurement year that received a prenatal care visit as a member of the MCO in the first trimester or within forty-two (42) Calendar Days of enrollment in the MCO; and the percentage of member deliveries that had a postpartum visit on or between twenty-one (21) and fifty-six (56) Calendar Days after delivery;
- PM #7–Antidepressant Medication Management (AMM). The number of members age eighteen (18) and older as of April 30 of the measurement year who were diagnosed with a new episode of major depression during the intake period and received at least eighty-four calendar days (12 weeks) of continuous treatment with antidepressant medication; and/or received at least one-hundred eighty calendar days (6 months) of continuous treatment with an antidepressant medication;
- PM #8–Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET). The total percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following: Initiation of AOD Treatment; and/or Engagement of AOD Treatment; and
- PM #9–Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC). The total percentage of children and adolescents one (1) through seventeen (17) years of age who were on two or more concurrent antipsychotic medications.

In 2020, New Mexico revised the Centennial Care 2.0 PMs and penalty structure. All PMs and targets are based on HEDIS technical specifications for the current year. Failure to meet the HSD designated target for individual performance measure during the calendar year will result in a monetary penalty based on two percent (2%) of the total capitation paid to the MCO for the contract/agreement year, divided by the number of performance measures specified in contract/agreement.

HSD established performance targets for four (4) years by applying the result of the CY 2018 MCO aggregated Audited HEDIS data, calculating an average increase for each CY until reaching the CY 2018 Quality Compass Regional Averages plus one (1) percentage point. The MCOs are required to meet HSD designated targets for CY 2020, 2021, 2022, and 2023 detailed with each PM below:

- PM #1 (1 point) – Well Child Visits in the First fifteen (30) Months of Life (W30). The percentage of Members who turned fifteen (15) months old during the measurement year and had six (6) or more well-child visits.
  - CY 2020 target is 62.62%.
  - CY 2021 target is 63.72%.
  - CY 2022 target is 64.82%.
  - CY 2023 target is 65.91%.
  
- PM #2 (1 point) – Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC). The percentage of Members ages three (3) through seventeen (17) years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity during the measurement year.
  - CY 2020 target is 48.52%.
  - CY 2021 target is 53.33%.
  - CY 2022 target is 58.14%.
  - CY 2023 target is 62.93%.
  
- PM #3 (1 point) – Prenatal and Postpartum Care (PPC). The percentage of Member deliveries of live births between October 8 of the year prior to the measurement years and October 7 of the measurement year that received a prenatal care visit as a Member of the CONTRACTOR’s MCO in the first trimester or within forty-two (42) Calendar Days of enrollment in the CONTRACTOR’s MCO.
  - CY 2020 target is 78.67%.
  - CY 2021 target is 80.70%.
  - CY 2022 target is 82.73%.
  - CY 2023 target is 84.75%.
  
- PM #4 (1 point) – Prenatal and Postpartum Care (PPC). The percentage of Member deliveries that had a postpartum visit on or between seven (7) and eighty-four (84) Calendar Days after delivery.
  - CY 2020 target is 63.35%.
  - CY 2021 target is 64.65%.
  - CY 2022 target is 65.95%.
  - CY 2023 target is 67.26%.
  
- PM #5 (1 point) – Childhood Immunization Status (CIS): Combination 3. The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday.
  - CY 2020 target is 68.01%.



- CY 2021 target is 69.27%,
  - CY 2022 target is 70.53%,
  - CY 2023 target is 71.78%.
- PM #6 (1 point) – Antidepressant Medication Management (AMM): Continuous Phase. The percentage of Members age eighteen (18) years and older as of April 30 of the measurement year who were diagnosed with a new episode of major depression during the intake period and received at least one-hundred eighty (180) Calendar Days (6 months) of continuous treatment with an antidepressant medication.
    - CY 2020 target is 34.33%,
    - CY 2021 target is 34.76%,
    - CY 2022 target is 35.19%,
    - CY 2023 target is 35.61%.
- PM #7 (1 point) – Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET): Initiation. The total percentage of adolescent and adult Members with a new episode of alcohol or other drug (AOD) dependence who received the following: Initiation of AOD Treatment.
    - CY 2020 target is 43.34%,
    - CY 2021 target is 44.74%,
    - CY 2022 target is 46.14%,
    - CY 2023 target is 47.54%.
- PM #8 (1 point) – Follow-Up After Hospitalization for Mental Illness (FUH): 30 Day. The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge.
    - CY 2020 target is 48.42%,
    - CY 2021 target is 50.22%,
    - CY 2022 target is 52.02%,
    - CY 2023 target is 53.80%.
- PM #9 (1 point) – Follow-Up After Emergency Department Visit for Mental Illness (FUM): 30 Day. The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness within 30 days of the ED visit.
    - CY 2020 target is 43.52%,
    - CY 2021 target is 45.01%,
    - CY 2022 target is 46.50%,
    - CY 2023 target is 48.00%.

- PM #10 (1 point) – Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD). The percentage of Members 18-64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
  - CY 2020 target is 80.63%,
  - CY 2021 target is 81.35%,
  - CY 2022 target is 82.07%,
  - CY 2023 target is 82.78%.

### **Centennial Care 2.0 Tracking Measures**

New Mexico has directed the MCOs to report on Tracking Measures (TMs) that focus on specific target populations to monitor and implement interventions for improvement, if needed. The TMs are based on HEDIS, CMS Adult Core Set or HSD defined technical specifications. HSD analyzes the TMs to identify performance trends, best practices, gaps in care and MCO interventions. Feedback is shared and discussed with the MCOs during quarterly quality workgroup meetings. The TMs do not have associated penalties. The Centennial Care 2.0 TMs are as follows:

- TM#1-Fall Risk Management: The percentage of Medicaid members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months and who received fall risk intervention from their current practitioner.
- TM#2-Diabetes, Short-Term Complications Admission Rate: The number of inpatient discharges with principal diagnosis codes for diabetes short-term complications for Medicaid members age 18 and older.
- TM#3-Screening for Clinical Depression and Follow-Up Plan: The percentage of Medicaid members age 18 and older screened for clinical depression using a standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.
- TM#4-Follow-up after Hospitalization for Mental Illness: Measure: Percent of seven-day follow-up visits into community-based Behavioral Health care for child and for adult members released from inpatient psychiatric hospitalizations stays of four or more days.
  - Inpatient Psychiatric Facility/Unit (IPF) – Discharges: For members, six (6) years of age or older at the time of discharge, who were hospitalized for treatment of mental health disorders for a continuous period of four days or more (i.e., discharge date more than three days after admission date). Includes only psychiatric units in general hospitals and freestanding psychiatric hospitals. For the purposes of tracking discharges and follow-ups, claims data should be used.
  - Follow-up after Hospitalization for Mental Illness: Discharges for members, six (6) years of age or older at the time of discharge, who were hospitalized for treatment of mental health disorders for a continuous period of four days or more and who had at least one follow-up visit with a mental health practitioner on or after the discharge

- date, within seven (7) Calendar Days of discharge. The follow-up service can be any service considered as outpatient, intensive outpatient or recovery treatment.
- Members who are enrolled with the MCO at the time of the member's discharge and are eligible for Medicaid services under New Mexico's State Plan. For purposes of this calculation, use age at time of discharge. Measure should be sorted by two categories and in two member groups:
    - Number of IPF Discharges of members six to seventeen (17) years of age during the quarter;
    - Number of IPF Discharges of members eighteen (18) years of age and older during the quarter;
    - Number of members six to seventeen (17) years of age who had a follow-up visit within seven days after an IPF Discharge during the quarter; and
    - Number of members eighteen (18) years of age and older who had a follow-up visit within seven days after an IPF Discharge during the quarter.
  - TM#5-Immunizations for Adolescents: Use current reporting year HEDIS technical specification for reporting. The percentage of adolescents thirteen (13) years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. Report rates for each vaccine and one combination rate.
  - TM#6-Long Acting Reversible Contraceptive (LARC): The MCO shall measure the use of Long-Acting Reversible Contraceptives (LARC) among members ages fifteen to nineteen (15–19).
  - TM#7-Smoking Cessation: The MCO shall monitor and report quarterly, the use of smoking cessation products and counseling utilization within a calendar year.
  - TM#8-Ambulatory Care: Use current reporting year HEDIS technical specification for reporting. Utilization of outpatient visits and emergency department (ED) visits reported by all member months for the measurement year.
  - TM#9-Annual Dental Visit: Use current reporting year HEDIS technical specifications for reporting. The percentage of enrolled members ages two (2) to twenty (20) who had at least one (1) dental visit during the measurement year.
  - TM#10-Controlling High Blood Pressure: Use current reporting year HEDIS technical specifications for reporting. The percentage of members ages eighteen (18) to eighty-five (85) who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.

### **Consumer Assessment of Healthcare Providers and Systems (CAHPS)**

New Mexico incorporates the CAHPS 5.0H survey required by NCQA for MCO accreditations as part of the required MCO 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 MCOs.

The results of the annual CAHPS survey are reviewed and analyzed by HSD to determine gaps in member satisfaction. Results are discussed with the MCOs during the quarterly quality meeting to identify interventions and strategies that the MCOs are applying to improve member satisfaction. The annual CAHPS reports are posted to the HSD website.

<https://www.hsd.state.nm.us/lookingforinformation/cahps-reports/>

## **Centennial Care Performance Improvement Projects**

CMS requirement CFR §438.340(b)(3)(ii)

**Elements of the State quality strategy. At a minimum, the State's quality strategy must include the following: A description of the performance improvement projects (PIPs) to be implemented in accordance with §438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO.**

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 PIPs are included in the MCO contracts and revised and updated based on HSD's review of the positive outcomes or the identification of needed attention to specific gaps in care.

The 2014 Centennial Care MCO contract directed the implementation of four (4) PIPs in the following areas:

- Long-Term Care Services
- Services to Children
- Behavioral Health
- Women's health

In January 2013 NM was awarded the Adult Medicaid Quality Grant (AMQG) and developed Quality Improvement Projects (QIPS) in the areas of Diabetes with a focus on prevention and enhanced disease management, and Behavioral health with a focus on screening and management for clinical depression. The AMQG ended in December of 2015, however, to promote sustainability of the project, HSD amended the MCO contracts to include the following four (4) PIPs:

- Long-Term Care Services
- Services to Children
- Diabetes Prevention and Management to include two (2) state directed measurement indicators:
  - Short term complications admissions rate
  - HgbA1c testing
- Screening and Management for Clinical Depression to include two (2) state directed measurement indicators:
  - Screening for clinical depression
  - Follow-up plan for members that screened positive for clinical depression

Centennial Care 2.0 PIPS: HSD revised and updated the MCO contracts by adding two (2) new PIPs and removing one (1). In 2019 the MCOs were directed to implement PIPs in the following areas:

- Long-Term Care Services
- Prenatal and Postpartum
- Adult Obesity
- Diabetes prevention and management to include two (2) state directed measurement indicators:
  - Diabetes short-term complication admissions
  - HbA1c testing
- Screening and management for clinical to include two (2) state directed measurement indicators:
  - Screening for clinical depression
  - Antidepressant medication management

HSD requires that each MCO implement work plans and activities consistent with PIPs as required by federal and state statutes, regulations and Quality Assessment and Performance Improvement Program requirements pursuant to § 438.330. The MCO is directed to design sound and meaningful quality studies that will have the greatest impact on individuals participating in the MCO. The MCOs may select interventions that are specific to the needs of the MCO targeted populations.

The EQRO conducts annual PIP validations on behalf of the State to determine MCO compliance with applying statistical analysis development and evaluation of the PIPs. Annual validation reviews by the EQRO are posted to the HSD website.

<https://www.hsd.state.nm.us/external-quality-review-organization-eqro-reports/>.

### **Home and Community Based Services (HCBS) Waiver Assurances**

New Mexico requires the MCOs to: ensure that their contracted HCBS providers meet HCBS Settings Rule Requirements; conduct Comprehensive Needs Assessments (CNAs) and Nursing Facility Level of Care (NF LOC) determinations according to established criteria; develop person centered care plans that include HCBS; implement an Electronic Visit Verification (EVV) system in Accordance with the 21<sup>st</sup> Century Cures Act; and negotiate HCBS rates with providers. There is no state fee-schedule or rate methodology. The MCOs' managed care rates are approved by CMS as required. Centennial Care 2.0 HCBS measures are as follows:

- Number and percent of enrolled licensed/certified providers who meet licensure /certification requirements prior to furnishing waiver services.
- Number and percent of enrolled non-licensed/non-certified providers who meet licensure /certification requirements prior to furnishing waiver services.
- Number and percent of provider training programs convened by the MCOs in accordance with MCOs' annual training plans and contractual requirements.

- Number of critical incidents by reporting category (abuse, neglect, exploitation, environmental hazard, emergency services, law enforcement, elopement/missing, and death).
- Dollar amount and percent of HCBS provider claims paid for by the MCOs within contractually required timeframes.
- Number and Percent of Comprehensive Care Plans (CCPs) that clearly document that the member was afforded a choice of waiver services and providers.
- Number and Percent of CCPs that address all needs and personal goals.
- Number and Percent of CCPs where services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the CCP.

In addition, New Mexico provides oversight and monitoring through the following activities:

- Quarterly MCO NF LOC determination audits.
- Instances of abuse, neglect, exploitation and unexplained deaths are reported by MCOs and providers into the web-based HSD Critical Incident Reporting (CIR) Portal. New Mexico monitors and assesses trends of reported incidents, including activities conducted to resolve reported incidents, to ensure the health, safety and welfare of Medicaid members. MCO policies and procedures are required to address and respond to incidents, including reporting incidents to the appropriate entities for further investigation. MCOs provide annual training and take corrective action as needed to ensure provider compliance with Critical Incident Reporting requirements.
- Provider enrollment for Agency Based Community Benefit (ABCB) service providers. All interested providers are required to submit an initial application and annual re-certification to HSD to demonstrate that all required provider qualifications are met. This process includes services that require licensing such as assisted living, adult day health, nursing, skilled maintenance therapies and environmental modifications. This process also includes ABCB providers that do not require licensure but do require approval by HSD through the provider credentialing process. Upon provider approval, HSD sends the MCOs a current list of approved ABCB providers to ensure the MCOs only contract with providers that have been credentialed/re-credentialed by HSD. The Fiscal Management Agency (FMA) certifies and enrolls all Self-Directed Community Benefit (SDCB) Providers. The MCOs contract directly with the FMA and are required by HSD to monitor this process to ensure that all SDCB provider requirements are continuously met.

### **Peer Delivered Pre-Tenancy & Tenancy Supportive Housing Measures**

New Mexico has modified the supportive housing program to include peer-delivered, pre-tenancy and tenancy support services to individuals with a Serious Mental Illness (SMI), who are homeless or precariously housed, and extremely low-income level. These services will expand on the basic housing support provided today through comprehensive community support services and will be delivered by peers in supportive housing programs associated with lead agencies. The addition of this service is intended to have a beneficial impact upon members by improving the integration of physical health and behavioral health services, improving treatment

participation and outcomes as well as reducing unnecessary hospitalizations and inappropriate use of the emergency department.

In 2018 Pre-Tenancy and Tenancy Supportive Housing Measures were realigned and are as follows:

- The number of households served with a Linkages voucher and support services;
- The number of months a member receives services through the Linkages Supportive Housing Program; and
- Members' choice of residency upon exiting the program.

The Linkages program is considered a Permanent Supportive Housing program and based on a Housing First whereby the client does have choice of residency before exiting the programming. Through programming the client receives a rental assistance voucher to apply to a permanent residency.

Success of the Linkages program is measures by the number of individuals/households who obtain a Linkages voucher. The voucher is applied to permanent housing and support services. Support services include at least one monthly house visit to include support with budget management, life skills, eviction prevention, etc. The Behavioral Health Services Division of HSD regularly provides support and guidance to the Linkages providers as needed.

#### **Directed Payments (Preprint)**

Pursuant to §438.6(c), HSD submits directed payment preprint proposals to CMS for approval which provides States the flexibility to implement delivery system and provider payment initiatives under the MCO contracts as a state directed payment.

Once approved, HSD uses directed payment arrangements to direct specific payments made by the MCOs to participating providers while utilizing outcome-based performance measures to evaluate the payment arrangement and assess the impact on improving access, quality and health outcomes for Medicaid beneficiaries.

HSD strives to select quality metrics that align with the Department 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, as reflected in the Directed Payments below:

- American Rescue Plan Act (ARPA) – Multi-year uniform increase for HCBS and personal care services. This preprint will sunset effective 6/30/2024.
- Community Tribal Hospitals – Multi-year 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.

- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) – Multi-year uniform increase for EPSDT services established by the state for Private Duty Nursing and Home Health. This preprint will sunset effective 6/30/2024.
- For Profit and Government Owned Hospitals – Multi-year uniform percent increase arrangement established by the state for inpatient and outpatient hospital services provided by for-profit/investor owned and governmental owned hospitals. This preprint will sunset effective 6/30/2024.
- Healthcare Quality Surcharge – Multi-year 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.
- Hospital Value Based Purchasing - Multi-year 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. This preprint will sunset effective 6/30/2024, as it will change to HealthCare Delivery Access Act (HDAA) effective 7/1/2024.
- Not For Profit Hospitals – Multi-year Uniform percent increase arrangement established by the state for inpatient and outpatient hospital services provided by not-for-profit community hospitals. This preprint will sunset effective 6/30/2024.
- Nursing Facility Value Based Purchasing – Multi-year 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.
- Pediatric – One-time State Directed Payment (a uniform percentage increase for all other inpatient hospital stays for general acute care hospitals, non-general acute care hospital utilization incurred by Medicaid enrollees under age 21 beginning January 1, 2023 through March 31, 2023.)
- Trauma Hospitals – Multi-year uniform percent increase established by the state for trauma hospitals. This preprint will sunset effective 6/30/2024.
- UNM Hospitals – Multi-year 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 – Multi-year 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.



### Proposed CY24 Directed Payments:

Miners Colfax IGT – pending submission for CMS approval

Ambulance Supplemental Payment Program (ASPP) IGT – pending submission for CMS approval

Rural Maternal OB – submitted to CMS on 4/12/24; pending approval

Primary Care VBP – pending submission for CMS approval.

### **External Independent Reviews**

[CMS requirement CFR §438.340\(b\)\(4\)](#)

**Elements of the State quality strategy. At a minimum, the State’s quality strategy must include the following: arrangements for annual, external independent reviews, in accordance with §438.350, of the quality outcomes and timeliness of, and access to, the services covered by each MCO.**

HSD, in accordance with 42 CFR 438.354, has retained the services of an External Quality Review Organization (EQRO), Island Peer Review Organization, to perform External Quality Reviews (EQRs). The EQRO will conduct all mandatory EQRs to assess quality outcomes and timeliness of, and access to, the services provided to Medicaid members and covered by each MCO.

The EQRO will follow CMS protocols for the following activities:

- Compliance Monitoring; an annual review designed to determine the MCO compliance with state and federal Medicaid regulations and applicable elements of the contract between the MCO and HSD;
- Validation of PMs; an annual review designed to evaluate the accuracy of HSD defined performance measures reported by the MCOs;
- Validation of PIPs; an annual review designed to verify the projects developed by the MCO were designed, conducted and reported in a methodically sound manner and address the target population defined by HSD;
- Validation of Network Adequacy; an annual review designed to determine the MCO compliance with state and federal Medicaid regulations and applicable elements of the contract between the MCO and HSD; and
- Technical Report; an annual report summarizing the findings on access and quality of care.

The MCOs are required to cooperate fully with the EQRO and demonstrate compliance with New Mexico’s managed care regulations and quality standards as set forth in federal regulation and state policy. The EQRO reports findings and recommendations to HSD and if appropriate, are incorporated into New Mexico’s Quality Strategy.

### **Transition of Care**

[CMS requirement CFR §438.340\(b\)\(5\)](#)

Elements of the State quality strategy. At a minimum, the State's quality strategy must include the following: a description of the State's transition of care policy required under §438.62(b)(3).

HSD is committed to providing the necessary supports to assist Medicaid members and requires the MCOs to establish policies and procedures that adhere to the standards defined by the Managed Care Policy Manual and MCO contract. The MCOs 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 MCOs 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 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 CCP 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 MCOs 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 EPSDT services;

- Transition for member(s) changing MCOs while hospitalized;
- Transition for member(s) changing MCOs during major organ and tissue transplantation services;
- Transition for member(s) changing MCOs while receiving outpatient treatment for significant medical conditions;
- Transition for member(s) changing MCOs;
- 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).

The MCOs 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, to include 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 MCOs 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. HSD requires the MCO to address at a minimum:

- Initiate an HSD 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 TOC plan, derived from the TOC 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; and
  - Safety.

HSD requires the TOC plan 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 MCO 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 (HRA) within three (3) business days of members' release or three (3) business days of notification of members release unless the member

The MCOs 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.

HSD requires the MCOs to perform an in-home assessment for members who are transitioning from an inpatient hospital or Nursing Facility stay to home and/or community and may be in need of Community Benefits within three (3) calendar days after the transition, followed by monthly contact for three (3) months. The assessment will address at a minimum:

- Safety in Home Environment;
- Physical Health Needs;
- Behavioral Health Needs;
- Housing Needs;
- Continuation of Medicaid Eligibility;
- Financial Needs;
- CNA if one is not in place; and
- Community Benefit needs and services in place.

HSD requires the MCOs to notify the assigned CYFD lead worker within thirty (30) business days prior to transition in care for CYFD involved children/youth.

For members who are preparing to receive out-of-state treatment, the MCOs are required to remain in active communication, including weekends and holidays, which may require daily updates with the member and/or authorized representative about the status of the out-of-state provider agreement and authorized treatment plan until treatment begins.

HSD requires the MCO that is receiving a member from another MCO to obtain relevant information and data from the transferring MCO in order to facilitate continuation of care and a seamless transition. The MCO shall ensure that a member entering the new MCO is held harmless by the Provider for the costs of Medically Necessary Covered Services incurred due to the transfer.

In the event a member is entering a MCO in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to enrollment in that MCO, the MCO is responsible for providing continued access to the prenatal care Provider (whether a Contracted or Non-Contracted Provider) through the postpartum period, without any form of prior approval. In the event a member entering the MCO is in her first trimester of pregnancy and is receiving medically necessary prenatal care services without any form of prior approval and without regard to whether such services are being provided by a Contracted or Non-Contracted

Provider for up to sixty (60) calendar days from the member's enrollment or until the member may be reasonably transferred to a Contracted Provider without disruption in care.

The MCOs are also required to minimize disruption of care and ensure uninterrupted access to medically necessary services for individuals transitioning between Medicaid and Qualified Health Plan coverage. The MCOs are required to establish and maintain transition guidelines for the coordination of services and establishment of phase-in and phase-out periods to address coverage transitions for members.

## **Health Disparities**

CMS requirement CFR §438.340(b)(6)

Elements of the State quality strategy. At a minimum, the State's quality strategy must include the following: The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. States must identify this demographic information for each Medicaid enrollee and provide it to the MCO at the time of enrollment.

In New Mexico many factors contribute to health disparities, including access to health care, behavioral choices, genetic predisposition, geographic location, poverty, environmental and occupational conditions, language barriers and social and cultural factors.

HSD enlists a variety of methodologies and resources, including enrollment files delivered daily to the MCOs, to identify, evaluate, reduce and overcome any barriers that limit access to appropriate care for New Mexico's Medicaid members. Resources include, but are not limited to:

- Stratified data tracking and monitoring of targeted populations, illness or chronic conditions to identify at risk Medicaid members;
- HSD directed interventions and oversight and monitoring of MCO directed interventions developed to address specific health care needs unique to Medicaid members;
- Requirement of MCOs to maintain an adequate provider network that adheres to HSD's provider participation standards;
- Establishment of a care coordination infrastructure to assess member needs;
- Member rewards program to encourage member engagement with preventive services and follow up care by incentivizing members to pursue healthy behaviors;
- Peer support program to provide formalized support and practical assistance to people who have or are receiving services to help regain control over their lives in their own unique recovery process; and
- Requirement of MCOs to develop a Cultural Competence and Sensitivity Plan to ensure that covered services provided to members are culturally competent and include provisions for monitoring and evaluating disparities in membership, especially as related to Native Americans.

## **Intermediate Sanctions**

CMS requirement CFR §438.340(b)(7)

Elements of the State quality strategy. At a minimum, the State's quality strategy must include the following: The appropriate use of the intermediate sanctions for MCOs.

New Mexico has established sanctions for the failure to meet certain contract requirements by the MCO, affiliate, parent or subcontractor, and if a party fails to comply with the contract, HSD may impose any or all of the non-monetary sanctions and monetary penalties if HSD determines the MCO acted or failed to act in the following ways:

- Fails substantially to provide Medically necessary services to a member;
- Imposes and/or collects Member premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program;
- Acts to discriminate among Members on the basis of their health status or need for Covered Services, including MCO initiated transfers or refusal to re-enroll a Member, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by members whose medical condition or history indicates probable need for substantial future covered services;
- Misrepresents or falsifies information that it furnishes to CMS or to the State;
- Misrepresents or falsifies information that it furnishes to a Member, potential Member or provider;
- Fails to comply with the requirements for physician incentive plans;
- Distributes, directly or indirectly, through any Major Subcontractor, Subcontractor, or Contract Provider, Marketing or Member Materials that have not been approved by the State or that contains false or materially misleading information; or
- Violates any of the other requirements of Sections 1903(m) or 1932 of the Social Security act, or any implementing regulations.

New Mexico may require a Directed Corrective Action Plans (DCAP) if it is determined that the MCO is not in compliance with one or more contractual requirements. New Mexico will issue a notice of deficiency, identifying the deficiency and follow-up requirements as directed in the DCAP. A notice from HSD of noncompliance that directs the DCAP will also serve as a notice of sanction in the event it is determined that sanctions are also necessary.

HSD may impose any or all of the non-monetary sanctions and monetary penalties to the extent authorized by federal and state law. Non-monetary intermediate sanctions may include:

- Suspension of auto-assignment of members in a MCO;
- Suspension of enrollment in the MCO;
- Notification to members of their right to terminate enrollment with the MCO without cause;
- Disenrollment of members by HSD;

- Suspension of payment for members enrolled after the effective date of the sanction and until CMS or HSD is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur;
- Rescission of Marketing consent and suspension of the MCO’s marketing efforts;
- Appointment of temporary management on any portion thereof for a MCO and the MCO shall pay for any costs associated with the imposition of temporary management; and
- Additional sanctions permitted under federal or state statutes or regulations that address areas of noncompliance.

HSD has established monetary penalties that may include:

- Actual damages incurred by HSD and/or members resulting from the MCO’s non-performance of obligations;
- Monetary penalties in an amount equal to the costs of obtaining alternative health benefits to a member in the event of the MCO's noncompliance in providing Covered Services. The monetary penalties shall include the difference in the capitated rates that would have been paid to the MCO and the rates paid to the replacement health plan. HSD may withhold payment to the MCO for damages until such damages are paid in full;
- Monetary penalties of up to five thousand dollars (\$5,000) per day when HSD has determined that the MCO has a deficiency in a specific area that is not improving;
- Monetary penalties up to five percent (5%) of the MCO's Medicaid capitation payment for each month in which the penalty is assessed;
- HSD reserves the right to assess a general monetary penalty of five hundred dollars (\$500) per occurrence with any notice of deficiency; and
- Other monetary penalties for failure to perform specific responsibilities or requirements.

PROGRAM ISSUES	PENALTY
Failure to comply with Claims processing as described in Section 4.19 of the Managed Care contract	Two percent (2%) of the monthly capitation payment per month, for each month that the HSD determines that the MCO is not in compliance with the requirements of Section 4.19 of the Managed Care contract
Failure to comply with Encounter submission as described in Section 4.19 of the Managed Care contract	Monetary penalties up to two percent (2%) of the MCO’s Medicaid capitation payment for each quarter in which the penalty is assessed. HSD will determine the specific percentage of the capitation penalty based on the severity or frequency of the infraction.

Failure to comply with the timeframes for a Comprehensive Needs Assessment for care coordination level 2 and level 3	\$1,000 per member where the MCO fails to comply with the timeframes for that member.
Failure to complete or comply with CAPs/DCAPs	0.12% of the monthly capitation payment per calendar day for each day the CAP/DCAP is not completed or complied with as required.
Failure to obtain approval of member Materials as required by Section 4.14.1 of the Managed Care contract	\$5,000 per day for each calendar day that HSD determines the MCO has provided member Material that has not been approved by HSD. The \$5,000 per day damage amounts will double every ten (10) Calendar Days.
Failure to comply with the timeframe for responding to Grievances and Appeals required in Section 4.16 of the Managed Care contract	\$1,000 per occurrence where the MCO fails to comply with the timeframes.
For every report that meets the definition for "Failure to Report" in accordance with Section 4.21 of the Managed Care contract	\$5,000 per report, per occurrence  With the exception of the cure period: \$1,000 per report, per calendar day. The \$1,000 per day damage amounts will double every ten (10) calendar days.
Failure to submit timely Summary of Evidence in accordance with Section 4.16 of the Managed Care contract	\$1,000 per occurrence.
Failure to have legal counsel appear in accordance with Section 4.16 of the Managed Care contract	\$10,000 per occurrence.
Failure to meet targets for the performance measures described in Section 4.12.8 of the Managed Care contract	A monetary penalty based on two percent (2%) of the total capitation paid to the MCO for the contract/agreement year, divided by the number of performance measures specified in the contract/agreement year.



<p>HSD can modify and assess any monetary penalty if the MCO engages in a pattern of behavior that constitutes a violation of this contract/agreement or, involves a significant risk of harm to members or to the integrity of Centennial Care. This may include, but is not limited to the following: Reporting metrics not met; failure to complete care coordination activities by the timeframes specified; failure to report on required data elements in report submissions; for a report that has been rejected by and resubmitted by the MCO up to three times and the report still meets the definition of “Failure to Report” in accordance with Section 4.21 of the contract; etc.</p>	<p>Monetary penalties up to five percent (5.0%) of the MCO’s Medicaid capitation payment for each month in which the penalty is assessed. HSD will determine the specific percentage of the capitation penalty based on the severity of the infraction, taking into consideration factors reasonably related to the nature and severity of the infraction.</p>
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Below is a total by year of HSD imposed and collected monetary penalties:

- 2014: \$8,552,459.08
- 2015: \$15,649,707.00 (Note: \$325,000.00 of the reported total was not recouped as the MCO was directed to pay this amount directly to a provider. Also, \$1,204,618.00 of the total reported was recouped for a partial Delivery System Improvement Project (DSIP) penalty.)
- 2016: \$9,608,519.84
- 2017: \$8,739,049.93
- 2018: \$10,424,030.70
- 2019: \$33,739,751.00

**Performance and Quality Outcomes**

CMS requirement CFR §438.340(b)(8)

Elements of the State quality strategy. At a minimum, the State’s quality strategy must include the following: A description of how the State will assess the performance and quality outcomes achieved by each PCCM entity.

New Mexico does not have PCCM entities.

**Long Term Services and Supports (LTSS)**

CMS requirement CFR §438.340(b)(9)

Elements of the State quality strategy. At a minimum, the State’s quality strategy must include the following: The mechanisms implemented by the State to comply with §438.208(c)(1) (relating to the identification of persons who need long-term services and supports or persons with special health care needs).

**Care Coordination Standards**

A comprehensive care coordination model fosters the goal of ensuring that Medicaid members receive the right care, at the right time, and in the right setting. MCOs determine levels of care

coordination for members based on an assessment identifying the level of support that is most appropriate to meet their needs. MCOs, or their delegate, conduct care coordination activities and functions based on the member's needs. In the event a member's needs should change, MCOs, or their delegate, are required to reassess the individual and, as appropriate, make the corresponding changes in their care coordination level of support.

HSD requires the MCOs, or their delegate, to conduct a standardized Health Risk Assessment (HRA) on members who are newly enrolled in Centennial Care or who are not in Care Coordination Level (CCL) 2 or 3 and have a change in health condition that requires a higher level of care coordination. The HRA will indicate if a member requires a Comprehensive Needs Assessment (CNA) to determine if the member should be assigned CCL 2 or 3. For members who have indicators that may warrant a NF LOC, the MCO will conduct a CNA and use the New Mexico Nursing Facility Level of Care Criteria and Instructions to determine NF LOC eligibility for members in need of Home and Community Based Services (HCBS) or Nursing Facility care. The results of the CNA and NF LOC assessment will be used to create the Comprehensive Care Plan (CCP) inclusive of the authorized HCBS services. MCOs are required to routinely monitor claims and utilization data for all members (including members who are not assigned to care coordination levels 2 or 3) to identify changes in health status and high-risk members in need of a higher level of care coordination.

Additional components of care coordination include:

- Assessing each member's physical, behavioral, functional and psychosocial needs;
- Identifying the specific medical, behavioral, LTSS and other social support services (e.g., housing, transportation or income assistance) necessary to meet the member's needs;
- Assessing members for LTSS. This applies to members of all ages who have functional limitations and/or chronic illnesses. The primary purpose is to support the ability of the 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. HSD defines members with special health care needs as those who have or are at increased risk for a disease, defect or medical condition that may hinder the achievement of normal physical growth and development and who also require health and related services of a type or amount beyond that required by individuals generally;
- Ensuring timely access and provision of services needed to help each member maintain or improve his or her physical and/or behavioral health status or functional abilities while maximizing independence; and
- Facilitating access to other social support services and assistance needed in order to promote each member's health, safety, and welfare.

## **Non-duplication of EQR Activities**

CMS requirement CFR §438.340(b)(10)

Elements of the State quality strategy. At a minimum, the State's quality strategy must include the following: The information required under §438.360(c)(relating to non-duplication of EQR activities).

HSD does not exercise the non-duplication option. HSD does not use information from Medicare or accreditation reviews to conduct annual External Quality Reviews. All required EQR activities including the mandatory annual reviews and validations are conducted by the HSD contracted EQRO.

HSD has a designated Contract Administrator authorized to represent HSD in all matters related to EQR. The Contract Administrator monitors the scope of work for the EQRO in comparison to those activities performed within HSD/MAD to ensure non-duplication of EQR activities.

## **Section III: Development, Revision and Evaluation of the Quality Strategy:**

CMS requirement CFR §438.340(c)(1)

Development, evaluation, and revision. In drafting or revising its quality strategy, the State must: Make the strategy available for public comment before submitting the strategy to CMS for review.

CMS requirement CFR §438.340(c)(1)(i)

Obtaining input from the Medical Care Advisory Committee (established by §431.12), beneficiaries, and other stakeholders.

CMS requirement CFR §438.340(c)(1)(ii)

Consulting with Tribes in accordance with the State's Tribal consultation policy.

CMS requirement CFR §438.340(c)(2)(i)

Review and update the quality strategy as needed, but no less than once every 3 years. The review must include an evaluation of the effectiveness of the quality strategy conducted within the previous 3 years.

CMS requirement CFR §438.340(c)(2)(ii)

The State must make the results of the review available on the Web site required under §438.10(c)(3).

CMS requirement CFR §438.340(c)(2)(iii)

Updates to the quality strategy must take into consideration the recommendations provided pursuant to §438.364(a)(4).

CMS requirement CFR §438.340(c)(3)(i)

Submit to CMS the following: A copy of the initial strategy for CMS comment and feedback prior to adopting it in final.

CMS requirement CFR §438.340(c)(3)(ii)

Submit to CMS the following: A copy of the revised strategy whenever significant changes, as defined in the state's quality strategy per paragraph (b)(11), are made to the document, or whenever significant changes occur within the State's Medicaid program.

CMS requirement CFR §438.340(d)

Availability. The State must make the final quality strategy available on the Web site required under §438.10(c)(3).

### **Development**

New Mexico's Quality Strategy is a coordinated, comprehensive, and pro-active approach to drive quality through targeted initiatives, comprehensive monitoring, and ongoing assessment of outcome-based performance improvement. The Quality Strategy was designed to ensure that services provided to Medicaid members meet or exceed the established standards for access to care, clinical quality of care and quality of services to achieve the delivery of high-quality and high value healthcare. HSD received approval for the initial Centennial Care Quality Strategy from CMS in May 2014.

### **Revision**

The Quality Strategy was reassessed in September 2017 and revised to address and evaluate the program outcomes through calendar year 2018. With the CMS approval of the 1115 Demonstration Waiver renewal application in December 2018, HSD has revised the Quality Strategy to include Centennial Care 2.0 metrics. All aspects of the Quality Strategy will be assessed for effectiveness to determine the need for further modifications. HSD defines significant change as; changes that materially affect the actual quality of information collected or analyzed. Any updates to the Quality Strategy based on "significant changes" shall be developed, reviewed, and submitted to CMS for review and feedback. Minor changes in timeframes, reporting dates, or format are not considered significant changes. New Mexico will submit a final draft of the Quality Strategy to (CMS) for comment and feedback. The Quality Strategy will be posted on the HSD website once approved.

HSD 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
- EQRO
- Behavioral Health Collaborative

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

### **Evaluation**

The Quality Strategy is evaluated annually by the EQRO in the Annual Technical Report to ensure alignment with reported outcomes from EQR validation reports, MCO audited HEDIS

reports, CAHPS survey, 1115 Waiver Evaluation report, HSD internal audits and MCO reports. The EQRO's evaluation assess how the Human Services Department 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 Centennial Care 2.0 enrollees. The EQRO's 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 EQR Annual Technical Report is posted to the HSD website annually.

[NM HSD 2021 External Quality Review Annual Technical Report](#)

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