HUMAN SERVICES
DEPARTMENT
MEDICAL ASSISTANCE DIVISION

NEW MEXICO

MEDICAID

MANAGED CARE PROGRAM

QUALITY STRATEGY

January 2019 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, Medical Assistance Division (HSD/MAD) implement a managed care program. A proposal was submitted under section 1915(b) of the Social Security Act to provide comprehensive medical and social services to 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/MAD implemented the Personal Care Option (PCO) as a state plan service to meet the needs of Medicaid members in need of long-term services and who met a Nursing Facility Level of Care (NF LOC). PCO was developed to allow members to receive care in their home rather than being placed in a nursing facility.

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

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

On March 18, 2005, 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/MAD 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.

The goals and objectives of Centennial Care are:

1. Assuring that Medicaid recipients received the right amount of care, at the right time, and in the right setting;
2. Ensuring that expenditures for care and services are measured in terms of quality and not quantity;
3. Slowing the growth rate of costs or "bending the cost curve" over time without cutting services, changing eligibility, or reducing provider rates; and
4. Streamlining and modernizing the program.

As part of the initial Centennial Care structure, HSD/MAD 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 place when they need them. Centennial Care increased access to LTSS for people who previously needed a waiver allocation to receive such services by allowing any Medicaid member who meets a NF LOC to access Home and Community Based Services (HCBS). As a result, 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/MAD 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. The waiver renewal builds upon the program's accomplishments and maximizes opportunities for targeted improvements and other modifications to Centennial Care. With the implementation of Centennial Care 2.0, New Mexico will continue efforts to transform its Medicaid program into an integrated, person-centered, value-based delivery system. Centennial Care 2.0 will continue to be driven by the established goals of Centennial Care.

The waiver renewal application builds upon the program's accomplishments and maximizes opportunities for targeted improvements and other modifications in the following key areas:

- 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.

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 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/MAD; 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/MAD.
- 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.

New Mexico's Quality Strategy utilizes a Continuous Quality Improvement (CQI) model to achieve goals and objectives outlined for the Centennial Care program. HSD/MAD, through the QM/QI standards, requires the MCOs to apply the CQI model and identify opportunities for measurable improvement in the health status of the population served by the MCOs. 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 HSD/MAD and the 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/MAD 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/MAD;
- 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/MAD that includes, but is not limited to:
    - A description of ongoing and completed QM/QI activities;
    - Inclusion of measures that are trended to assess performance;
    - Findings that incorporate prior year information and contain an analysis of any demonstrable improvements in the quality of clinical care and service;
    - Development of future work plans based on the incorporation of previous year findings of overall effectiveness of QM/QI program;
    - Demonstration that active processes are implemented that measure associated outcomes for assessing quality performance, identifying opportunities for improvement, initiating targeted quality interventions and regularly monitoring each intervention's effectiveness;
    - Demonstration that the results of QM/QI projects and reviews are incorporated in the QM/QI program;
    - Incorporation of annual HEDIS results in the following year's plan as applicable to HSD/MAD 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 about behavioral health aspects of the MCOs' annual QM/QI work plan during the New Mexico Behavioral Health Collaborative quarterly meeting.

Utilization Management Standards

HSD/MAD 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/MAD 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/MAD 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/MAD 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 care on an ongoing basis. 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/MAD. Violation, breach or noncompliance with the accreditation standards may be subject to termination for cause as detailed in the contract.

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 utilizes data that evaluates the MCOs' strengths and opportunities for improvement in serving the Medicaid population by specifying Performance Measures (PMs) and Performance Improvement Projects (PIPs). PMs, PIPs and performance targets are reasonable, based on industry standards, and consistent with CMS EQR Protocols. Annual reviews of the PMs and PIPs are conducted by New Mexico's EQRO and posted on the HSD website. 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.

New Mexico requires 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 Performance Measures are 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.

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/MAD defined technical specifications. HSD/MAD and BHSD analyze 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.

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 21st 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/MAD 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/MAD to demonstrate that all required provider qualifications are met. This process includes services that require licensing such as assisted living, adult day health, nursing,

maintenance therapies and environmental modifications. This process also includes ABCB providers that do not require licensure but do require approval by HSD/MAD through the provider credentialing process. Upon provider approval, HSD/MAD 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/MAD. 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). 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. The Pre-Tenancy and Tenancy Supportive Housing Measures are as follows:

- The number of months a member receives services through the Linkages Supportive Housing Program.
- Members' choice of residency upon exiting the program.
- Occurrences of hospitalization during the period a member is receiving services through the Linkages Supportive Housing Program.

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.

In January 2013, New Mexico was awarded the Adult Medicaid Quality Grant (AMQG) by CMS. The grant was designed to support the development of staff to collect, report, and analyze data for adults enrolled in Medicaid. New Mexico developed Quality Improvement Projects (QIPs) in accordance with the Initial Adult Core Set Technical Specification and selected Diabetes; Prevention and Enhanced Disease Management, and Behavioral Health; Screening and Management for Clinical Depression. The AMQG ended in December of 2015, and to promote sustainability of the projects associated with the AMQG, the MCOs' contracts were amended in 2015 directing the MCOs to incorporate these ongoing QIPs as PIPs, going forward.

New Mexico continues the projects associated with the AMQG and requires the Centennial Care 2.0 MCOs to implement Performance Improvement Projects (PIPs) in the following areas: one

(1) Long-Term Care Services; one (1) Prenatal and Postpartum; one (1) Adult Obesity; and two (2) State directed PIPs. The two state directed PIPs include: one (1) Diabetes prevention, and management; and one (1) Screening and management for clinical depression. The PIP work plans and activities must be consistent with requirements outlined in federal and state statutes, regulations and Quality Assessment and Performance Improvement Program requirements pursuant to § 438.330.

External Independent Review

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/MAD, 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/MAD;
- Validation of PMs; an annual review designed to evaluate the accuracy of HSD/MAD 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/MAD;
- 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/MAD; 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/MAD and if appropriate, are incorporated in to 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/MAD 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; and
- Safety.

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. 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.

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/MAD 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/MAD 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/MAD 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/MAD enlists a variety of methodologies and resources, including enrollment files delivered daily to the MCOs, to identify, evaluate, reduce and overcome any barriers that limit access to appropriate care for 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/MAD 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/MAD'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, New Mexico may impose sanctions.

New Mexico has the option to apply Corrective Action Plans (CAPs) if it is determined that the MCO is not in compliance with one or more requirements. New Mexico may issue a notice of deficiency, identifying the deficiency and follow-up recommendations/requirements (either in the form of a CAP or a Directed Corrective Action Plan (DCAP). A notice from HSD/MAD of noncompliance that directs a CAP or DCAP may also serve as a notice of sanction in the event it is determined that sanctions are also necessary.

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

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

- Suspension of payment for members enrolled after the effective date of the sanction and until CMS or HSD/MAD 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/MAD has established monetary penalties that may include:

- Actual damages incurred by HSD/MAD 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/MAD 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/MAD 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/MAD 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.

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.	Monetary penalties up to five percent (5.0%) of the MCO's Medicaid capitation payment for each month in which the penalty is assessed. HSD will determine the specific percentage of the capitation penalty based on the severity of the infraction, taking into consideration factors reasonably related to the nature and severity of the infraction.

Below is a total by year of HSD/MAD imposed and collected monetary penalties:

- 2014: $2,069,457.14
- 2015: $4,997,484.27 (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 DSIPT penalty.)
- 2016: $6,104,840.61
- 2017: $8,739,049.93

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.

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 place. 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/MAD 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/MAD 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.

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

HSD/MAD conducts internal quality review activities apart from the EQRO activities, such as:

- Care coordination audits evaluating and monitoring MCO care coordination activities. HSD/MAD monitors monthly progress reports from the MCOs outlining the MCOs' efforts to improve care coordination practices according to HSD/MAD's findings that required follow-up to recommendations and action steps;
- "Ride-alongs" by HSD/MAD staff were conducted with MCO care coordinators in 2015, 2016, 2017 and 2018 to observe care coordinator visits with members in the home setting. HSD/MAD ride-alongs identified the need to continue care coordination trainings for member assessments and available services. Modifications to assessment tools and technical assistance were provided to the MCOs based on the observations. MCOs acknowledged the need for continued training and that the process was helpful to the MCO care coordinators. The ride-alongs focus on application by care coordinators of the Community Benefit Services Questionnaire (CBSQ), a tool developed collaboratively by HSD/MAD and the MCOs to educate members about available Home and Community Based Services. HSD/MAD observed the MCOs' care coordinator use of the Community Benefit Member Agreement (CBMA) to document if the member agrees to accept or decline available services; and
- Monitoring MCO continued expansion of the PCMH model by engaging PCMH providers to conduct care coordination activities for their attributed members through Value Based purchasing (VBP) arrangements. Centennial Care 2.0 seeks to expand this initiative by continuing to transition care coordination functions from the MCOs to the provider level (known as a delegated model). Monitoring of VBP initiatives shall occur through MCO reporting to HSD/MAD.

HSD/MAD strives to set standards to continually improve health care and social services throughout the state of New Mexico. HSD/MAD will continue to monitor the requirements listed in the MCO contracts by completing annual audits, conducting quarterly meetings with the MCOs, and analyzing quarterly/annual reports.

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/MAD 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/MAD 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/MAD 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/MAD 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/MAD.

Evaluation

HSD/MAD will continue to utilize a CQI model to evaluate and assess the effectiveness of the Quality Strategy. The Quality Strategy is evaluated annually to ensure alignment with reported outcomes from EQR technical reports, MCO audited HEDIS reports, CAHPS survey, 1115 waiver evaluation report, HSD/MAD internal audits and MCO reports, including QM/QI program evaluations. The outcomes will be utilized to gauge effectiveness of the Quality Strategy and to determine if any necessary changes or updates to the Quality Strategy are warranted. EQR technical reports, MCO audited HEDIS reports and CAHPs survey results are posted to the HSD website on annual basis.

The table below reflects the aggregate percentage by calendar year of the annual HEDIS results reported to HSD/MAD.

Performance Measures	2014	2015	2016	2017
PM #1 Annual Dental Visits	64.00%	66.01%	67.60%	70.27%
PM #2 Use of Appropriate Medication for People with Asthma	46.29%	52.68%	54%	56.03%

PM #3 Controlling High Blood Pressure	52.56%	53.68%	54.25%	49.88%
PM #4 Comprehensive Diabetes Care				
HbA1C testing	85.01%	84.12%	83.54%	85.74%
HbA1C >9%	47.24%	49.80%	47.65%	48.40%
Retinal Eye Exam	55.03%	51.76%	55.43%	54.69%
Nephropathy Screening	79.06%	87.30%	88.71%	87.59%
PM #5 Prenatal/Postpartum Visits				
Prenatal visits within first trimester or within 42 days of enrollment	73.00%	70.66%	76.75%	73.05%
Postpartum visit on or before 21 & 56 days after delivery	54.82%	51.16%	57.83%	57.21%
PM #6 Frequency of on-going prenatal care	52.09%	45.95%	55.81%	*
PM #7 Antidepressant Medication Management				
Acute Phase 84 days	55.61%	53.14%	50.37%	48.67%
Continuous Phase 180 days	41.12%	37.77%	34.87%	33.21%
PM #8 Follow up after hospitalization for Mental illness				
7 days	43.81%	37.58%	41.15%	38.04%
30 days	65.35%	60.86%	63.81%	61.60%

*NCQA retired the measure.

The table below reflects the aggregate percentage by calendar year of the Tracking Measure results reported to HSD/MAD.

Tracking Measure	Description of Target Population or Topic	2014	2015	2016	2017
Fall Risk Management	The Percentage of Medicaid members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 Months and who received fall risk intervention from their current practitioner.	12%	8%	12%	13%

Diabetes, Short-Term Complications Admission Rate	The number of inpatient discharges with a principal diagnosis code for diabetes short-term complications for Medicaid enrollees.				
	18 to 64 years of age	22%	17%	19%	14%
	65 + years of age	88%	95%	60%	69%
Screening for Clinical Depression and Follow-Up Plan	The percentage of Medicaid enrollees screened for clinical depression using a standardized depression screening tool and if positive a follow-up plan is documented on the date of the positive screen.				
	18 to 64 years of age	0.2%	0.07%	0.12%	0.23%
	65 + years of age	0.04%	0.24%	0.26%	0.32%
Well-Child Visits in the First 15 Months of Life	The percentage of members who turned 15 months old during the measurement year and who had 6 or more well-child visits with a PCP during their first 15 months of life.	*NR		58%	61%
Children and Adolescents' Access to Primary Care Practitioners (PCP)	The percentage of members 12 months – 19 years of age who had a visit with a PCP.	*NR		61%	57%
Long Acting Reversible Contraceptive (LARC)	The use of LARC among members age 15 -19 years of age.	*NR		3106 (# of members)	2831 (# of members)
Smoking Cessation	The monitoring of smoking cessations products: Cost utilization	*NR		$1,146,190	$1,394,474.73
	The monitoring of counseling: Products and Services (Total Units) utilization			7609	8189

*NR- Measures were not required by contract to be reported for that time.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

HSD/MAD incorporates the CAHPS 5.0H Survey required by NCQA for accreditation as part of the required MCO annual report submissions. CAHPS 5.0H allows for inclusion of state specific questions and provides information on New Mexico's Medicaid members and their experiences with the services provided. Below is a table with the Supplemental questions and results for 2015, 2016, and 2017.

CAHPS Supplemental Questions *CCC-Children with Chronic Conditions *NR- Not Reported	Year	BCBS		MHC		PHP		UHC	
Child Care Coordination									
1. In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these doctors or other health providers? (% answering Yes)	2015	27%	43% CCC	64%	71% CCC	52%	60% CCC	NR	
	2016	28%	28% CCC	27%	44% CCC	14%	29% CCC	56%	51% CCC
	2017	26%	26% CCC	22%	40% CCC	20%	38% CCC	31%	44% CCC
2. In the last 6 months, who helped to coordinate your child's care?									
Someone from your child's health plan	2015	4%	8% CCC	13%	14% CCC	4%	9% CCC	NR	
	2016	6%	6% CCC	5%	6% CCC	13%	20% CCC	5%	10% CCC
	2017	5%	5% CCC	3%	7% CCC	14%	19% CCC	5%	8% CCC
Someone from your child's doctor's office or clinic	2015	4%	8% CCC	13%	14% CCC	4%	9% CCC	NR	
	2016	22%	22% CCC	24%	31% CCC	63%	57% CCC	29%	35% CCC
	2017	20%	20% CCC	23%	29% CCC	46%	54% CCC	22%	23% CCC
Someone from another organization	2015	1%	4% CCC	6%	10% CCC	6%	7% CCC	NR	
	2016	3%	3% CCC	2%	4% CCC	0%	6% CCC	2%	6% CCC
	2017	3%	3% CCC	2%	7% CCC	6%	8% CCC	2%	5% CCC

A friend or family member	2015	5%	6% CCC	1%	1% CCC	3%	3% CCC	NR	
	2016	4%	4% CCC	5%	3% CCC	9%	3% CCC	6%	3% CCC
	2017	6%	6% CCC	5%	3% CCC	2%	1% CCC	6%	5% CCC
You	2015	71%	60% CCC	25%	27% CCC	39%	31% CCC	NR	
	2016	65%	65% CCC	64%	56% CCC	16%	14% CCC	59%	46% CCC
	2017	66%	66% CCC	67%	54% CCC	32%	19% CCC	65%	59% CCC
3. How satisfied are you with the help you received to coordinate your child's care in the last 6 months?									
Satisfied or Very Satisfied	2015	81%	74% CCC	86%	87% CCC	91%	88% CCC	NR	
	2016	77%	77% CCC	90%	86% CCC	86%	87% CCC	84%	77% CCC
	2017	75%	75% CCC	85%	84% CCC	96%	93% CCC	82%	81% CCC
Adult Care Coordination									
4. In the last 6 months, did anyone from your health plan, doctor's office, or clinic help coordinate your care among these doctors or other health providers? (% answering Yes)	2015	33%		24%		27%		NR	
	2016	38%		30%		29%		37%	
	2017	35%		26%		29%		32%	
5. In the last 6 months, who helped to coordinate your care?									
Someone from your health plan	2015	9%		19%		17%		NR	
	2016	14%		12%		34%		12%	
	2017	14%		17%		27%		18%	
Someone from your doctor's office or clinic	2015	25%		48%		47%		N/A	
	2016	26%		23%		48%		21%	
	2017	24%		50%		47%		24%	

Someone from another organization	2015	2%	3%	4%	N/A
	2016	4%	1%	1%	5%
	2017	2%	4%	2%	2%
A friend or family member	2015	14%	16%	13%	N/A
	2016	14%	11%	8%	23%
	2017	14%	4%	12%	5%
You	2015	50%	16%	19%	N/A
	2016	43%	53%	9%	39%
	2017	46%	28%	12%	51%
6. How satisfied are you with the help you received to coordinate your care in the last 6 months?					
Satisfied or Very Satisfied	2015	80%	87%	88%	NR
	2016	74%	81%	94%	79%
	2017	73%	70%	87%	81%
Member Education					
7. In the last 6 months, have you received any material from your health plan about good health and how to stay healthy? (% answering Yes)	2015	58%	59%	62%	NR
	2016	73%	57%	63%	67%
	2017	61%	55%	63%	60%
8. In the last 6 months, have you received any material from your health plan about care coordination and how to contact the care coordination unit? (% answering Yes)	2015	50%	48%	50%	NR
	2016	60%	54%	51%	59%
	2017	58%	39%	51%	48%
Care Plan					
9. Did your care coordinator sit down with you and create a plan of care? (% answering Yes)	2015	24%	24%	64%	NR
	2016	28%	25%	54%	35%
	2017	33%	32%	59%	33%

10. Are you satisfied that your care plan talks about the help you need to stay healthy and remain in your home?					
Satisfied or Very Satisfied	2015	70%	71%	NR	NR
	2016	70%	83%	84%	71%
	2017	73%	72%	90%	71%
Fall Risk					
11. A fall is when your body goes to the ground without being pushed. In the last 6 months, did you talk with your doctor or other health provider about falling or problems with balance or walking? (% answering Yes)	2015	22% (12 mo.)	18%	22%	NR
	2016	23% (12 mo.)	17%	57%	29%
	2017	22%	19%	72%	27%
12. Did you Fall in the past 6 months? (% answering Yes)	2015	19%	18%	17%	NR
	2016	21%	15%	52%	25%
	2017	18%	14%	46%	26%
13. In the past 6 months, have you had a problem with balance or walking? (% answering Yes)	2015	27%	24%	25%	NR
	2016	26%	20%	21%	40%
	2017	29%	25%	30%	38%
14. Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? (% answering Yes)	2015	23%	23%	26%	NR
	2016	26%	21%	58%	38%
	2017	27%	22%	63%	35%