

New Mexico Consumer Guide



Help in Choosing a Quality Managed Care Plan

How Plans in New Mexico Compare

The Member's Point of View
Helping You Stay Healthy
Children's Health
Managing Illness
And More...

Released February 2000



State of New Mexico
Health Policy Commission

Dear New Mexican Consumer:

This third edition of the *New Mexico Consumer Guide* provides information comparing how well managed care plans are doing from the member's point of view, as well as ranking the health plans, services in the areas of children's and women's health and managing illness. In addition, there is information on new services available from the Public Regulation Commission's Office of Managed Care along with details about your rights as a consumer. The state Health Policy Commission collects information on health care and has developed this guide for New Mexicans to make sure that differences in health care quality will be reported to consumers in an unbiased and meaningful way.

This reference guide provides information comparing managed care plans. Although managed care can be less costly than traditional fee-for-service health insurance, these types of plans play a greater role in coordinating the health care you receive and the network of providers who deliver your health care. With this guide as a reference, consumers can make sure they are still getting quality health care when they choose managed care plans.

Whether you are in excellent health or have a chronic condition, this report is relevant to you. Use this book as a reference. Information is also available on our web site at <http://hpc.state.nm.us>. So that the Commission can continue to deliver information for comparing your health care choices please help us improve future reports by providing feedback on page 26.

Working toward improved health care for all New Mexicans, that is our primary goal.

Sincerely,

A handwritten signature in black ink, appearing to read "Edwin P. Vigil".

Edwin P. Vigil
Chair, Health Policy Commission

Table of Contents

What Information Matters Most to You?

Sources of Information	2
Understanding Differences in Quality.....	3
12 Questions to Ask	4
Worksheet: Compare Your Options	5
Summary Rankings	6
Detail Charts:	
The Member's Point of View	
Information about their Providers	8
Getting Access to Providers	9
Getting Access to Care and Information	10
Member Satisfaction with the Plan and the Care Received	11
Children's Health	
Prenatal Care and Birth	12
Caring for Your Child's Health	13
Women's Health	
Helping Women Stay Healthy	15
Care During Pregnancy and After Birth	16
Managing Illness	
Keeping Illnesses Under Control	17
Surgical Care for Women	18
Surgical Care for Men	19
General Information	
Provider Certification	20
Members and Providers Staying with the Plan.....	21
Plan Finances: How the Dollars are Spent	22
Use of Services: Comparing New Mexico to the Nation	23
Your Rights and Responsibilities/Complaints and Grievances	24
Evaluation Form: Did you find this guide helpful?	26
List of MEDICARE Managed Care Plans	27
What is Behind the Summary Rankings	28
Managed Care Plans in this Guide - See inside of back cover.	

Sources of Information

The role of government: The state Health Policy Commission acts as a health information clearinghouse so that the same information is collected from each plan and reported. In this way fair comparisons can be made. (See the inside back cover for the list of managed care plans in this report.)

Sources of information:

- 1. Members were asked to evaluate their health plans.** Each managed care plan used the same national member satisfaction questionnaire. In 1999, members answered detailed questions about their interaction with their providers, health plan customer service representatives and about getting access to needed care. The member's point of view is presented on pages 8 through 11.
- 2. Performance ratings, based on clinical health care services in 1998,** were calculated and submitted to the state by managed care plans. This basic set of information on managed care performance was developed by the National Committee for Quality Assurance (NCQA), an organization that monitors quality and sets standards for managed care organizations nationwide. Performance ratings start on page 12.

The accuracy of the information:

- 1. The Member's Point of View.** Member satisfaction surveys were conducted, analyzed and submitted by certified survey firms, at each plan's expense, before the health plans saw the results. Consumers can be very confident that this information reflects what members actually said.
- 2. Performance ratings** depend on data collected, maintained and submitted by each plan. The best way to be sure the data is accurate is with a standard audit by a qualified independent firm. This costly process checks the numbers, computer systems, medical records review and other processes used to collect the data and calculate the rates. Less than half of the plans in this report verified their information by audit (see page 3).

Other kinds of information:

- 1. What about benefits and cost?** Because employers often choose the package of health benefits to offer its employees, consumers carrying the same health insurance may have very different covered services and out-of-pocket costs. Your employer is the best source for this kind of information.
- 2. This report does NOT cover traditional fee-for-service plans.** In exchange for greater choice of providers and sometimes health care options, fee-for-service plan members shoulder more of the responsibility for the quality of their health care choices. The state does not monitor these plans in the same way.

* One source of the data used in this publication is Quality Compass® and is used with the permission of the NCQA. Any analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA.

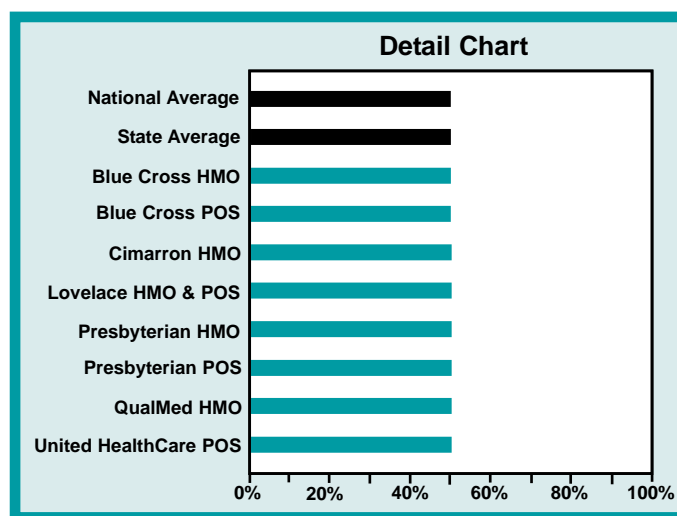
Understanding Differences in Quality

Judging differences: Many factors make up quality, and managed care plans may not be as good at delivering quality care in one area as they are in another. The purpose of the New Mexico Consumer Guide *Help in Choosing a Quality Managed Care Plan* is to provide facts about the managed care plans operating in New Mexico and to show consumers how each plan performs in specific areas of health care. The results are displayed in two ways in this report: **Summary Rankings and Detail Charts.**

The summary rankings on pages 6 and 7 show, at a glance, how well New Mexico managed care plans perform. Each summary table ranks plans from 0 (lowest) to 10 (highest) based on more detailed results (described below). Results from managed care plans nationwide that publicly report this information were used to create a “yardstick”. A plan with a rank of 4 in the sample table means that 3 out of 10 (30%) of the plans in the nation ranked lower than that plan but 6 out of 10 (60%) ranked higher. For a detailed description of the calculations behind the summary rankings, see page 28.

Blue Cross HMO	4
Blue Cross POS	4
Cimarron HMO	4
Lovelace HMO & POS	4
Presbyterian HMO	4
Presbyterian POS	4
QualMed HMO	4
United HealthCare POS	4

The detail charts on page 8 through 23 show results on each specific performance measure reported by New Mexico plans. Higher scores mean better performance, but small differences may not be meaningful. The charts include national and state averages (black bars), which are standards for comparing an individual plan’s results to how most managed care plans perform.



A word about accuracy: Consumers can have greater confidence that the data submitted by plans is correct when an audit is performed. Lovelace Health Plan and Presbyterian Health Plan both had qualified independent audit firms verify their plan’s clinical results that begin on page 12.

Making your choice: Look at the results important to you and your family in this report and all of the information available to you before making a decision. The Personal Worksheet on page 5 will help you compare and prioritize your health plan choices.

12 Questions to Ask

What You Should Know Before You Make Your Choice

A health plan should provide you with a detailed description of benefits being covered, an ID card, a member handbook, a list of doctors and hospitals under contract with the plan and other information you request.

Here are some questions to ask the health plan you are considering or your employer benefits representative:

1. Is my regular doctor part of the plan's network (or list) of providers?
2. If I am under the care of a specialist, is he or she part of the plan's network?
3. If I need services from a specialist not in the plan's network, will the plan make exceptions?
4. What are the plan's policies about pre-existing health problems?
5. Are there providers to choose from in the plan's network close to where I live or work?
6. Is there a hospital in the plan near my home?
7. Can I use the drugstore I am now using? If not, are the plan's drugstores conveniently located?
8. How and where do I obtain after-hours care?
9. How do I receive care if I am traveling or away from home?
10. Does the plan require prior authorization for care from specialists? How do I go about this?
11. What are my premium costs? Co-payments? Deductibles?
12. Does the plan offer translation services if needed?



Contact the plans - The phone numbers of managed care plans in New Mexico are listed inside this book's back cover. Your employer's benefits manager is another person to ask. For information on the **quality of managed care plans** use this book as your reference.

Worksheet: Compare Your Options

Your Personal Worksheet

Use the worksheet below to help you compare and prioritize your health plan choices. Use information from this Guide, your employer and the managed care plans.

- Quality:** Place a check in the box for each plan that meets your needs in each Quality category.
- Benefits and Cost:** Place a check in the box for the plans that offer the benefits you want and fit your budget. Review benefit and cost information from your employer or the plan.
- Doctors / Hospitals:** Place a check in the box if your preferred doctor and/or hospital is listed with the plan. Review the plan’s physician directories and telephone the customer service departments.
- Score** each plan by adding up the checks in each row. *Is this the right plan for you?*

Plan	Quality Which plan scored well on the quality ratings in this Guide?						Benefits & Cost	Doctors / Hospitals	Score
	The Member's Point of View See pages 8-11	Children's Health See pages 12-14	Women's Health See pages 15-16	Managing Illness See pages 17-19	General Information See Pages 20-22	Use of Services See page 23			
Blue Cross Blue Shield HMO									
Blue Cross Blue Shield POS									
Cimarron Health Plan HMO									
Lovelace HMO & POS									
Presbyterian Health Plan HMO									
Presbyterian Health Plan POS									
QualMed HMO									
United HealthCare POS									

Summary Rankings

Looking for Quality

Health Plan Ranking

How the plan ranks based on the percent of members who gave their plan a high rating*.

Blue Cross HMO	1
Blue Cross POS	1
Cimarron HMO	0
Lovelace HMO & POS	4
Presbyterian HMO	3
Presbyterian POS	2
QualMed HMO	7
United HealthCare POS	3

The member's point of view reveals a lot about health plan quality. A summary of members' answers to survey questions about their actual health care experiences is presented on this page. The summary charts on this page and the next cover broad areas of interest to consumers, but they do not cover all aspects of health care. See pages 8 to 23 for more detailed information.

Getting Access to Providers

The ranking is based on the percent of members who had "no problem" accessing primary care providers and specialist.

Blue Cross HMO	3
Blue Cross POS	3
Cimarron HMO	2
Lovelace HMO & POS	6
Presbyterian HMO	5
Presbyterian POS	5
QualMed HMO	4
United HealthCare POS	2

Ranking of Health Care Received

Ranking based on the percent of members who gave a high rating* to the health care they received from plan providers.

Blue Cross HMO	4
Blue Cross POS	2
Cimarron HMO	1
Lovelace HMO & POS	4
Presbyterian HMO	2
Presbyterian POS	3
QualMed HMO	5
United HealthCare POS	2

Stability of Provider Network

Ranking based on how many primary care providers stayed with the plan from 1997 to 1998.

Blue Cross HMO	1
Blue Cross POS	1
Cimarron HMO	1
Lovelace HMO & POS	3
Presbyterian HMO	4
Presbyterian POS	4
QualMed HMO	2
United HealthCare POS	7

Getting Access to Health Care

This ranking is based on the percent of members who said it was not a problem to get a referral to a specialist when they needed one.

Blue Cross HMO	1
Blue Cross POS	1
Cimarron HMO	0
Lovelace HMO & POS	3
Presbyterian HMO	1
Presbyterian POS	1
QualMed HMO	4
United HealthCare POS	2

* A high rating means 8, 9 or 10 on a scale of 0 (worst) to 10 (best).

Summary Rankings

How Managed Care Plans Compare

The eight tables on pages 6 and 7, based on services in 1998, rank each plan using member ratings and other areas of health plan performance. The tables show how New Mexico plans compare to plans nationwide that publicly report this information. See page 3 for more information on using these summary rankings to understand differences in quality.

Plans are ranked on a scale of 0 (lowest) to 10 (highest) compared to plans in the nation.



NR = an audit determined the information was not accurate.

NA = means the number of members was too small to get a meaningful result.

Women's Health Care

The percent of regular screening (breast and cervical cancer tests) and follow-up after child birth women in each plan received.

	Breast Cancer	Cervical Cancer	Follow Up
Blue Cross HMO	1	6	7
Blue Cross POS	3	1	1
Cimarron HMO	0	7	0
Lovelace HMO & POS	3	7	3
Presbyterian HMO	NR	NR	NR
Presbyterian POS	NR	NR	NR
QualMed HMO	6	3	4
United HealthCare POS	1	1	1

Caring for your Child's Health

The ranking is based on the percent of children in each plan who received the recommended immunizations (vaccinations) and routine well-child visits.

	Vaccinations	Well-child visits
Blue Cross HMO	3	2
Blue Cross POS	0	0
Cimarron HMO	0	1
Lovelace HMO & POS	2	5
Presbyterian HMO	3	NR
Presbyterian POS	2	NR
QualMed HMO	3	1
United HealthCare POS	0	1

Managing Illness

The ranking is based on the percent of eye exams for people with diabetes and the percent of provider follow-up within 30 days after hospitalization for mental illness.

	Eye Exams	Mental Health
Blue Cross HMO	6	6
Blue Cross POS	1	6
Cimarron HMO	1	NA
Lovelace HMO & POS	5	2
Presbyterian HMO	1	NR
Presbyterian POS	2	NR
QualMed HMO	2	6
United HealthCare POS	1	NA

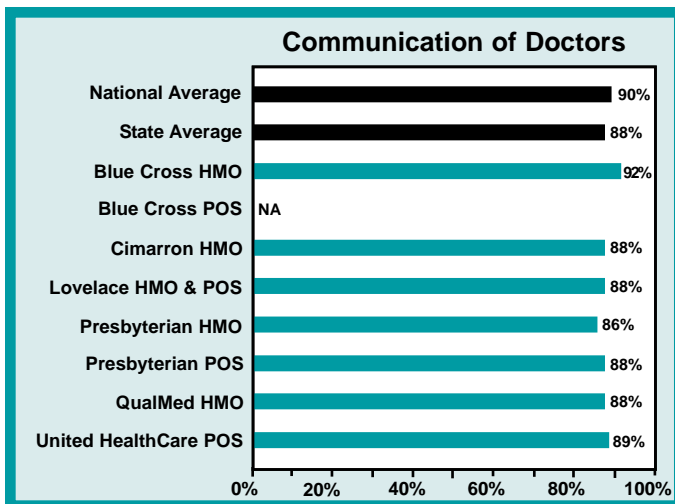
The Member's Point of View

Information about their Providers

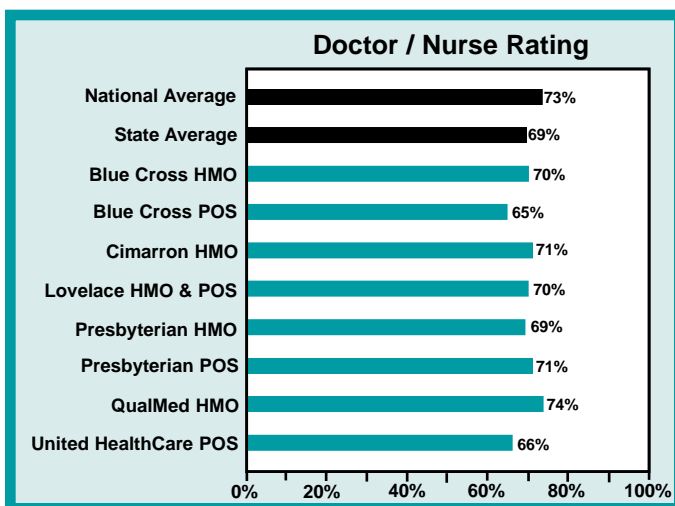
How the information on this page is useful in choosing a plan:

The patient and their doctor are partners in preventing and managing illnesses. Clear and knowledgeable guidance and explanation from a doctor or other health provider can make the difference in the patient understanding their illness, their symptoms and following the prevention and treatment plan correctly. The plan is responsible for having an appropriate selection of qualified providers for you to choose from.

Compare how each plan measures up: Clear communication between the provider and patient helps develop trust. A high score for communication with providers in the plan network is favorable.



How well providers communicated. The chart on the left shows the overall percent of managed care plan members who said that the doctors or other health providers in the plan network “usually” or “always” communicated well. It combines members’ answers to questions about how often the provider listened carefully, explained things in a way that they could understand, showed respect for what they had to say, and spent enough time with them.



Members rated their primary care provider on a scale of 0 (worse doctor or nurse practitioner possible) to 10 (best doctor or nurse practitioner possible). The percent of providers in each health plan’s network that received a high rating (an 8, 9 or 10) is shown in the chart on the left.

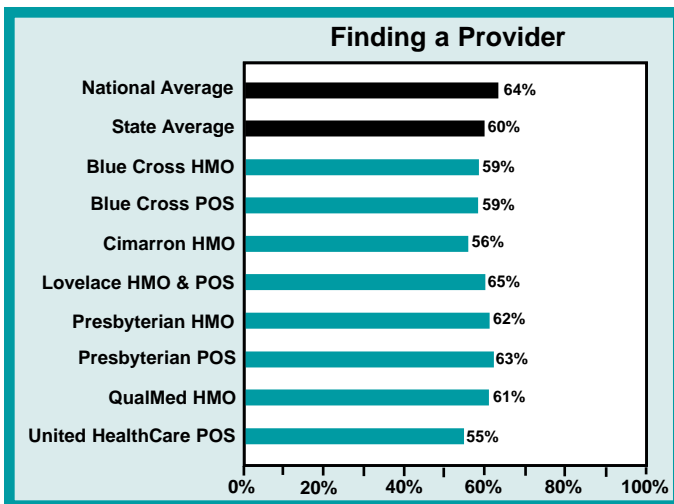
NA = means the data was not available.

The Member's Point of View

Information about Getting Access to Providers

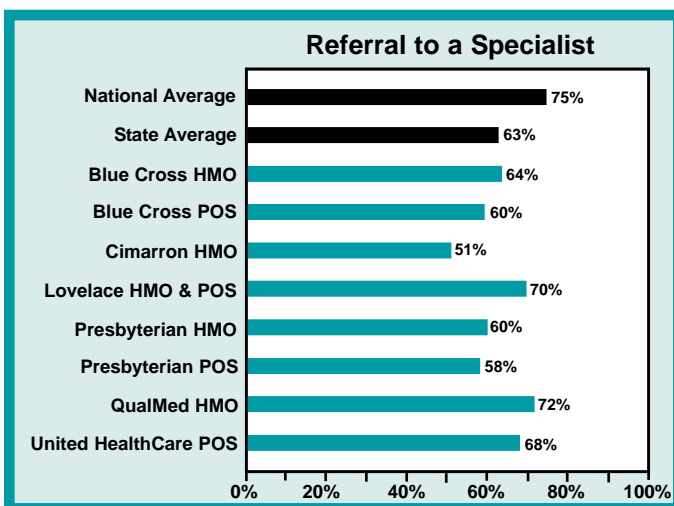
How the information on this page is useful in choosing a plan: Managed care plans have a network of primary care providers you can use. They also review decisions these providers make about referrals to specialists. (Often traditional plans review doctors referrals before deciding whether to pay for a service, too.) This can be a plus in terms of limiting unnecessary costs and medical treatment but is a cause for concern when access to providers and care is too restricted.

Compare how each plan measures up in meeting or doing better than state and national targets for access to primary care providers and specialists. Higher scores can give you more confidence that access to primary care professionals and specialists is readily available.



How easy will it be to find a provider?

The chart on the left shows the percent of people who **said it was not a problem** to find a primary care provider (doctor, nurse practitioner or physician assistant) they were happy with.



Getting a referral to a specialist. This chart shows the percent of members who needed a referral to a specialist and **said it was not a problem** to get one from the managed care plans in this guide.

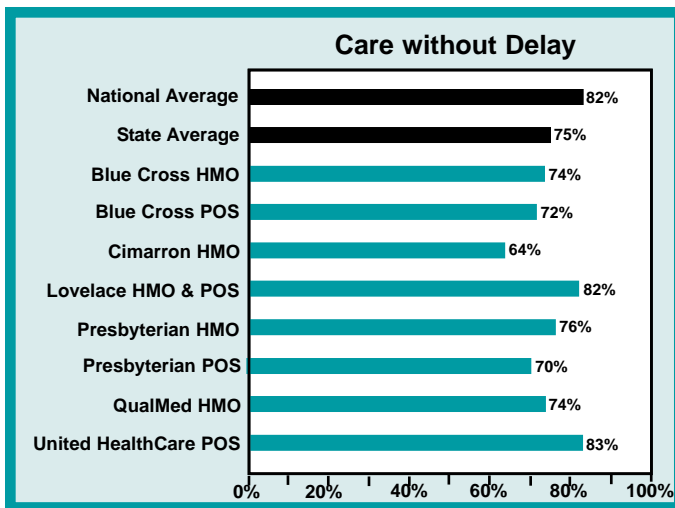
The Member's Point of View

Information about Getting Access to Care and Information

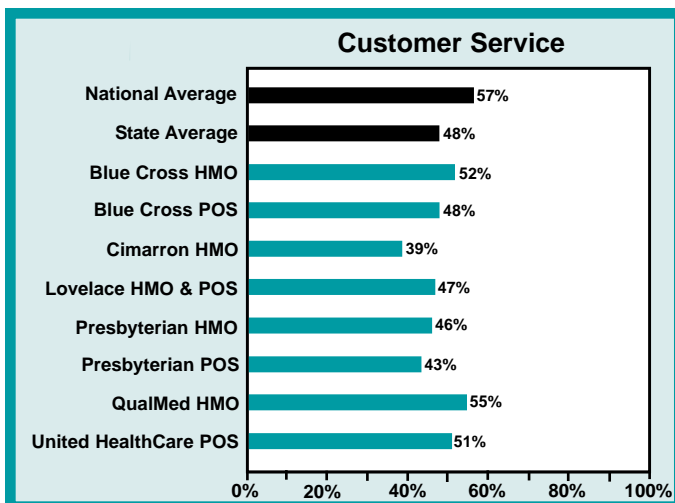
How the information on this page is useful in choosing a plan: You and/or your employer are paying for health coverage, so you can expect the health plan to be responsive to your health care needs.

- When an approval from your health plan is necessary for care you or your doctor believes is necessary, approval should be timely and not affect your health.
- When you call the health plan you can expect to get good service. When choosing a health plan it is useful to know how helpful, responsive and customer-friendly members felt their plans were when they called customer service.

How each plan measures up: High scores can give you more confidence that approval for specialist care and service is readily available.



Did members get the care they needed without delays? The chart shows what percent of members in each plan said that there was **not a problem of delays** in health care while they waited for approval from the plan.



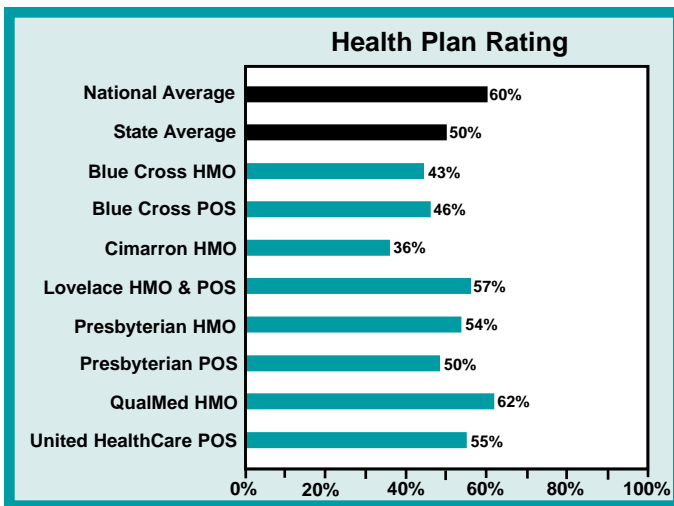
Getting help from customer service. Members were asked how much a problem, if any, was it for them to get the help they needed when they called their health plan for customer service. The percent of members in each plan **reporting no problem** is shown.

The Member's Point of View

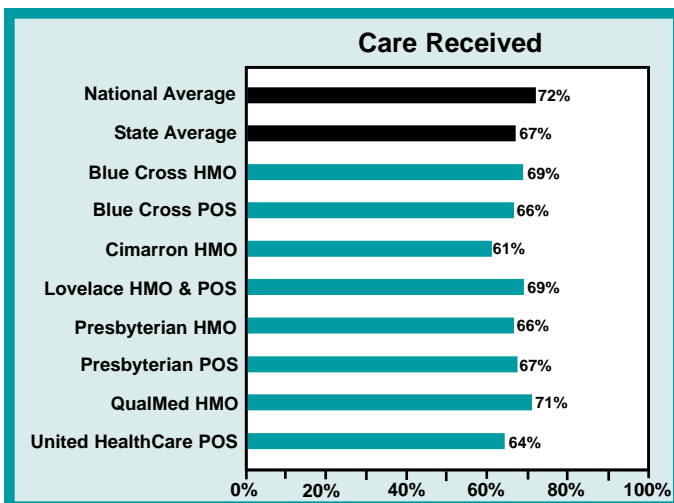
Member Satisfaction with the Plan and the Care Received

How the information on this page is useful in choosing a plan: Satisfaction with a managed care plan is an indicator of the overall quality of service that the plan offers. Satisfaction with the care received may be influenced by the operational procedures of the plan, the personal doctor or nurse, and specialist care as well as other experiences the member has in the process of seeking and obtaining health care.

How each plan measures up: High scores show that members are satisfied with their experience with the plan and the care they are receiving.



Members rated the plan on a scale of 0 (worst) to 10 (best). The chart shows the percent of members who gave their plan a high (8, 9 or 10) rating.



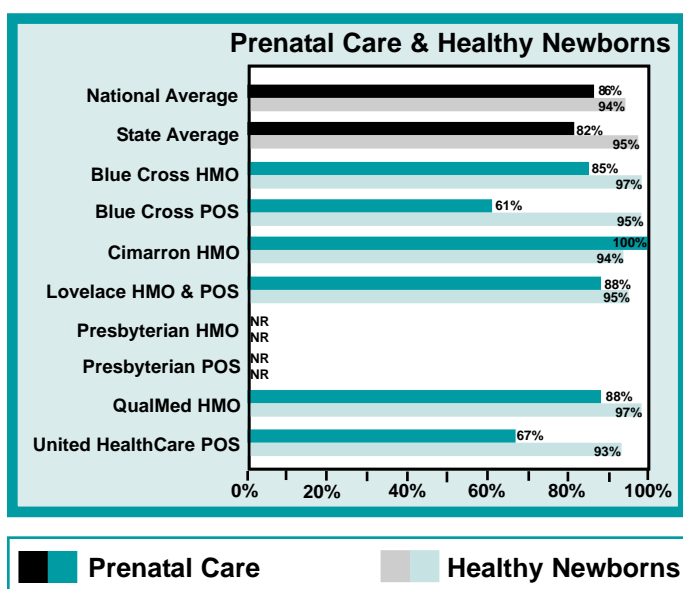
Members rated the care they received on a scale of 0 (worst) to 10 (best). The chart shows the percent of members who gave their plan a high (8, 9 or 10) rating.

Children's Health

Information about Prenatal Care and Birth

How the information on this page is useful in choosing a plan: Early prenatal care can increase the chance of a healthy newborn. Although a lot depends on lifestyle choices the expectant mother makes (nutrition, smoking, seeking care), health plans can have an impact through patient outreach and education. Plans also have a responsibility to make sure they are making prenatal care readily available for members in communities they serve.

Compare how each plan measures up: The chart allows you to compare the percent of women who received prenatal care next to the percent of healthy newborns for each plan. Overall, New Mexico plans performed better (95%) compared to the national percent (94%) of newborns born without medical problems.



Prenatal care in the first trimester -

Prenatal care early in pregnancy includes coaching the expectant mom toward a healthy diet, lifestyle, vitamin supplement use and other choices as well as closely following the developing life. The darker bar in each pair of bars in the chart shows the percent of women who delivered a baby in 1998 that received early prenatal care.

Having healthy newborns - The chart shows how many healthy newborns (as opposed to those who had medical problems) were born to members in each plan. Only women between 10 and 49 years old are included in these numbers for a more equitable plan comparison.



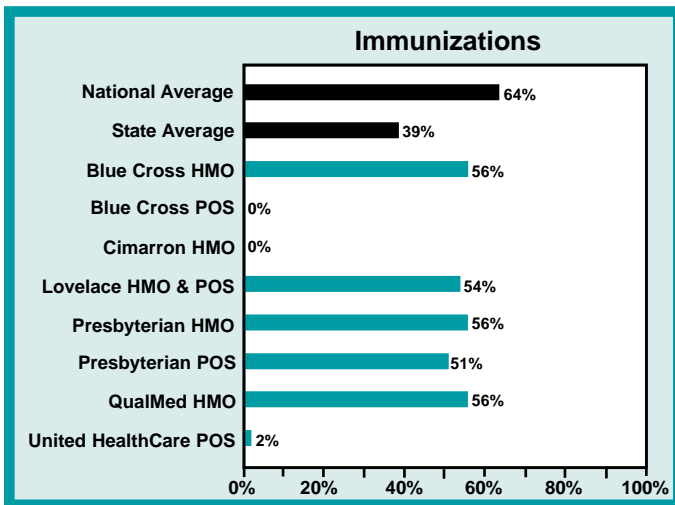
NR = an audit determined the information was not accurate.

Children's Health

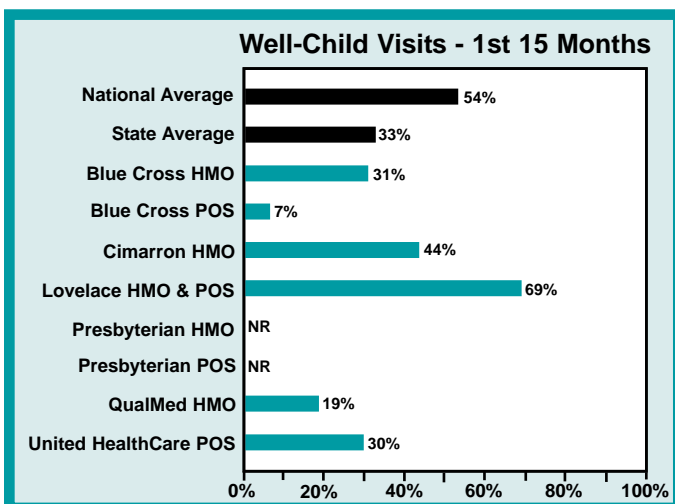
Information about Caring for your Child's Health

How the information on this page is useful in choosing a plan: It is important for children to see their health care provider regularly, especially in the first and second years of life and to receive immunizations for protection from serious diseases. Their provider checks their physical, mental and social development. Plans can help by educating parents about why this is important and to encourage providers to offer weekend or evening hours. Rates of well-child care and immunizations are sometimes higher in plans that provide these kinds of supports.

Compare how each plan measures up: Use the charts to compare the percent of children in the different managed care plans in New Mexico that received routine well-child visits and immunizations, and then compare how they are doing compared to the national rates.



Are children receiving their routine immunizations? The chart shows the percent of children in each plan that were fully immunized by age two. Because it is a challenge gathering data from the many locations where children receive immunizations, these immunization rates may not represent all the children being immunized.



Six well-child visits in the first 15 months of life is recommended by the American Academy of Pediatrics. The percent of children that had at least six visits in their first 15 months of life is shown.

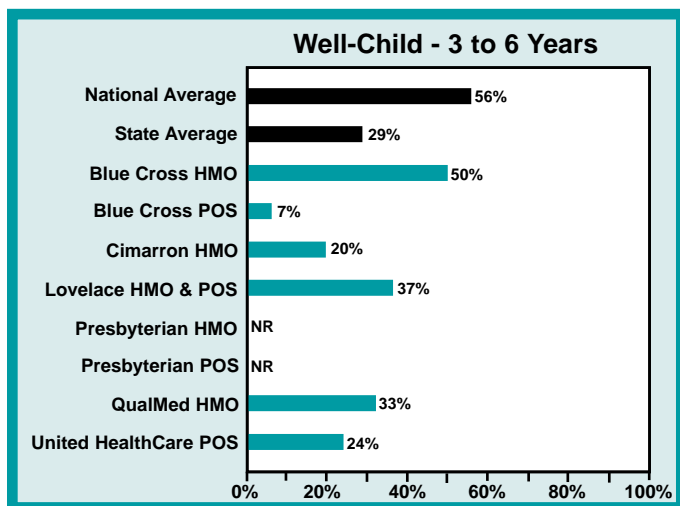
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Children's Health

Information about Caring for your Child's Health

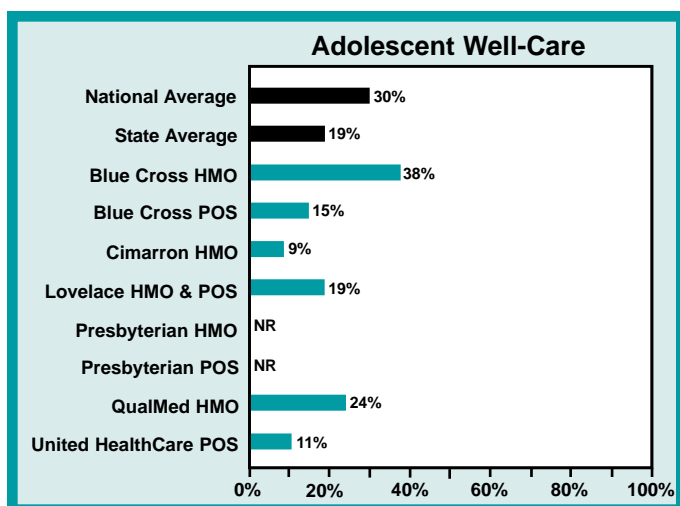
How the information on this page is useful in choosing a plan: It is important for children to see their care providers each year in their pre-school and early school years to detect physical or developmental problems. Later, in adolescence, well care includes promoting healthy lifestyles and interventions that can prevent physical and emotional problems. Some ways that plans can help is to educate parents about bringing in their children not only for sick care, but for well care too.

Compare how each plan measures up: Use the charts to compare the percent of young children and adolescents in the different managed care plans that received routine well care visits and then compare how they are doing compared to the national rates.



Well-child visits for 3, 4, 5 and 6 year olds.

The American Academy of Pediatrics recommends annual primary care visits for this age group. The percent of children who were 3, 4, 5 and 6 years of age that had at least one well-child visit in 1998 is listed.



Adolescent well-care visits are an important opportunity for providers to check on the medical needs and habits of teens. The chart shows the percent of adolescents from 12 to 21 years old that had at least one comprehensive well-care visit with their health care provider in 1998.

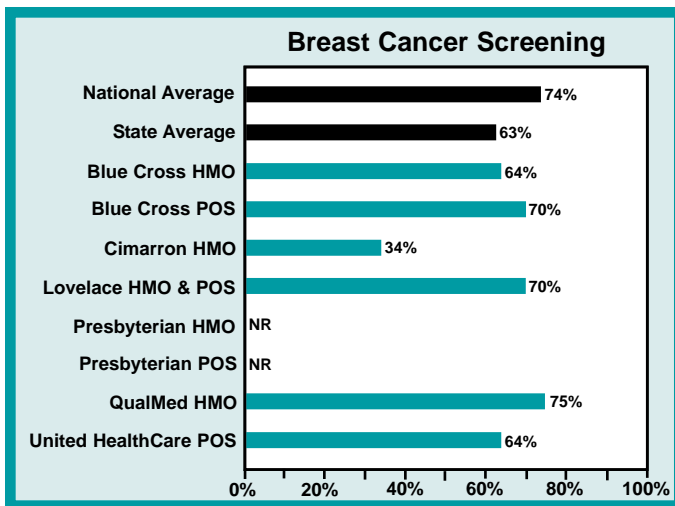
NR = an audit determined the information was not accurate.

Women's Health

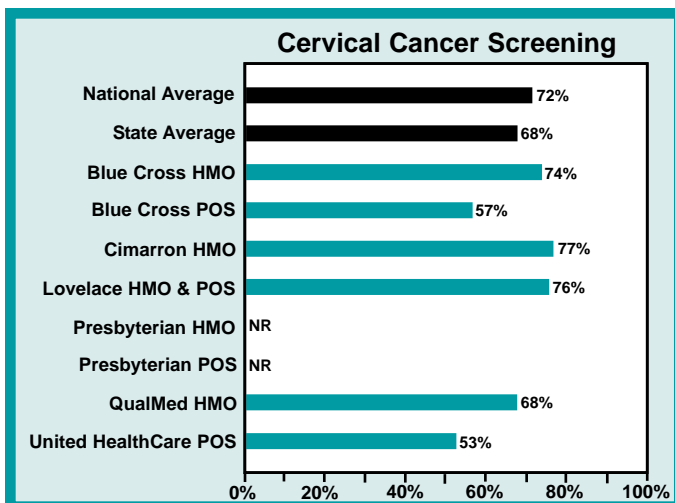
Information on Helping Women Stay Healthy

How the information on this page is useful in choosing a plan: Early detection of cancer, such as cervical and breast cancers, has been shown to save lives. A managed care plan can take an active role in encouraging women to get routine screening for cancer. Educational campaigns and sending reminders on members' birthdays are some of the techniques plans use to do this.

How each plan measures up: Use the charts to compare what percent of women members in each managed care plan actually received each type of screening. Plans and their providers with rates at or above the national and/or state average are performing better at providing cancer screening.



Breast cancer screening by a mammogram (a test to find breast cancer) is currently medically recommended every one to two years for women who are over 50 years of age to detect signs of breast cancer early. This chart shows the percent of women plan members 52 to 69 years old who had a mammogram during a two year period.



Cervical cancer screening is a test, also called a Pap smear, to detect signs of cervical cancer. Early detection means more positive outcomes. Current medical guidelines recommend that women 21 to 64 years old be screened at least every 3 years. This chart shows the percent of women plan members who had a Pap smear during a three year period.

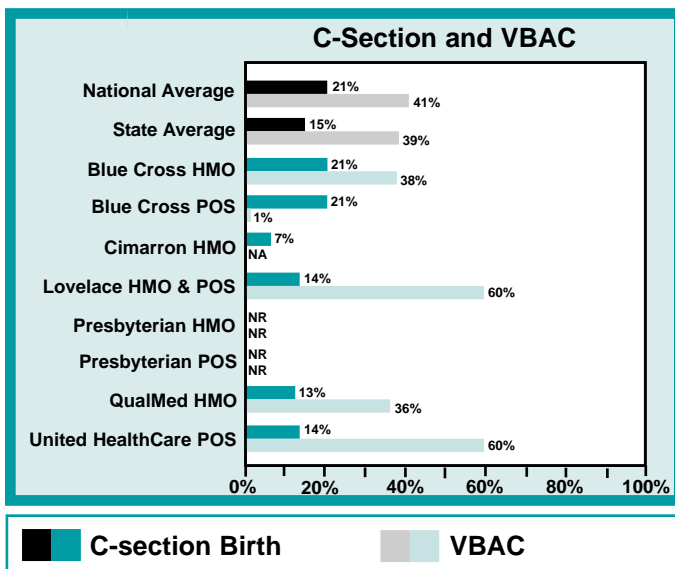
NR = an audit determined the information was not accurate.

Women's Health

Women's Health Care During Pregnancy and After Birth

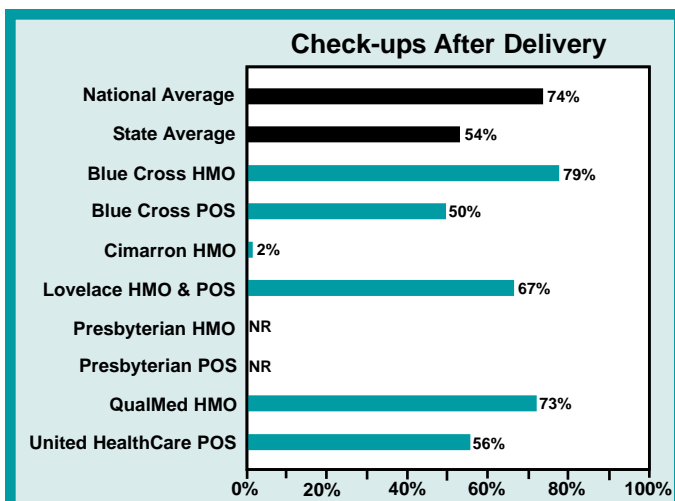
How the information on this page is useful in choosing a plan:

- There are appropriate reasons for an obstetrician to perform a Cesarean section (C-section) - a procedure for delivering an infant surgically - for example, fetal distress. The procedure is sometimes performed unnecessarily for reasons such as physicians' or patients' convenience. Disadvantages of C-section are exposure to the risks of surgery and higher rates of newborn complications. When choosing a plan women may wish to take note of high C-section rates.
- Vaginal delivery after a birth via C-section is encouraged under the right circumstances.
- A check-up for new mothers in the weeks after birth is important to ensure they get proper care and any necessary assistance. Providers can initiate this visit by accurately tracking deliveries and to follow-up with new mothers to schedule check-up appointments.



Comparing C-section deliveries and vaginal birth after C-section (VBAC) -

The chart allows you to compare the percent of all births in 1998 that were delivered by C-section (darker bar) in each plan. The lighter bar in each pair of bars indicates how many deliveries during the year were vaginal births after a C-section, a practice now encouraged. Unusually high rates for C-sections are not desirable, whereas higher rates for vaginal births after a C-section (VBAC) are a positive sign.



Are new mom's receiving routine check-ups after delivery?

The chart shows the percent of women who successfully delivered that had a postpartum visit between 3 to 8 weeks after delivery. Higher rates mean plan providers are doing a good job of seeing new mothers for check-ups.

NA = means the number of members was too small to get a meaningful result.

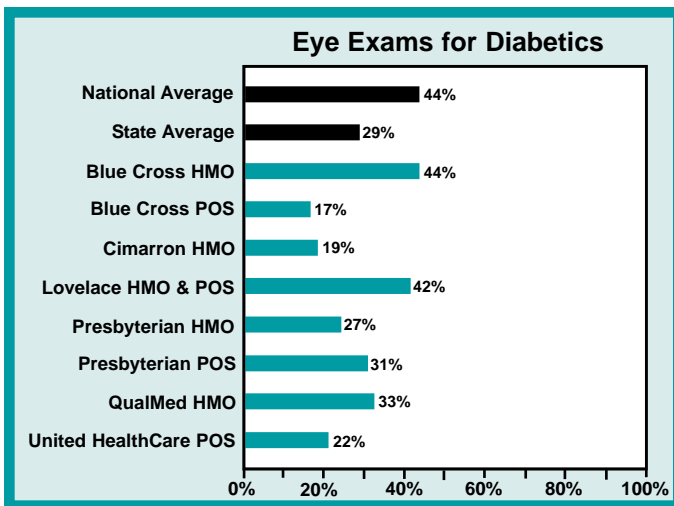
NR = an audit determined the information was not accurate.

Managing Illness

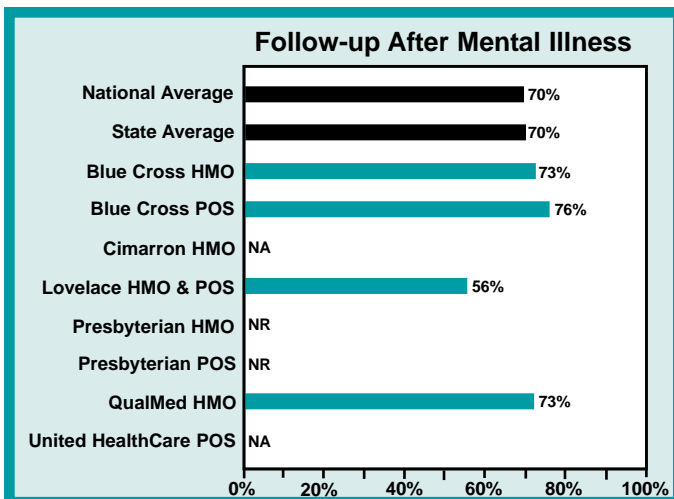
Information on Keeping Illnesses Under Control

How the information on this page is useful in choosing a plan: Some kinds of care help detect illness, while other treatments are used to keep illness under control for patients diagnosed with chronic conditions. Diabetes, for example, is the leading cause of adult blindness; therefore, it is important that people with diabetes have their eyes examined regularly. Follow-up care after hospitalization for mental illness is important in lowering suicide risks, detecting early medication problems and helping the patient transition back to the home or work environment.

How each plan measures up: For people who have a serious illness, health plans with rates at or above the national and/or state average are performing better at managing illnesses like diabetes or mental illness. A plan with a higher rate of follow-ups after mental health hospitalization is doing better at providing continuing care for members with a mental illness.



The rate of eye exams for people with diabetes measures the percent of members age 31 and older in each plan that had an eye exam in the past year.



Follow-up after hospitalization for mental illness indicates the percent of plan members who were hospitalized for mental illness and were seen as an outpatient by a mental health professional within 30 days after their discharge.

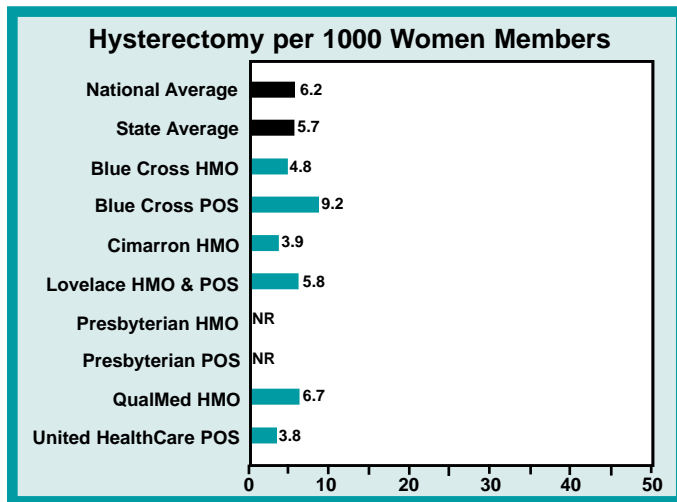
NA = means the number of members was too small to get a meaningful result.

NR = an audit determined the information was not accurate.

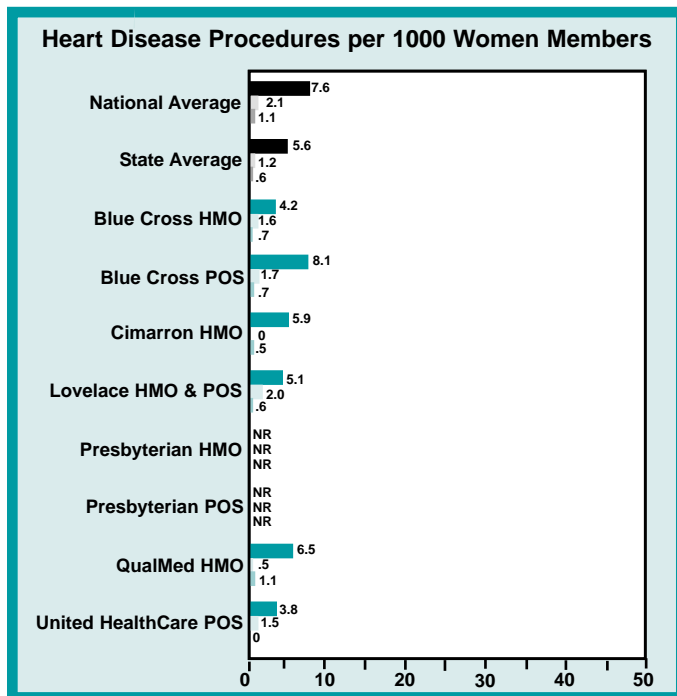
Managing Illness

Information on Surgical Care for Women

How the information on this page is useful in choosing a plan: People may find the information below especially relevant if they or family members experience an illness that requires one of the hospital procedures described below. This information also provides some insight on how each plan manages use of inpatient care. There are many reasons that the frequency a procedure is performed is different from plan to plan, including patient preference, different standards of care, and how healthy members of each plan generally are. Plans can also influence these rates through their policies, financial incentives offered to their physicians and special disease management programs they offer.



Hysterectomy is the surgical removal of the uterus or womb. This chart shows the rate of hysterectomy performed per 1000 members who are women age 45 to 64 years old. Care should be taken when considering the hysterectomy rate. A high rate may suggest that hysterectomy may be performed when other less costly or less invasive treatment options are available. A very low rate may indicate plans controlled use of hysterectomies.



Common procedures to diagnose and treat heart disease - Three procedures are commonly used to diagnose and treat heart disease. Coronary angiogram (cardiac catheterization) is used to determine the location and severity of heart disease. Angioplasty and coronary artery by-pass graft (CABG) are used to surgically treat coronary artery heart disease. The chart shows how frequently cardiac catheterizations, angioplasty and coronary artery by-pass grafts (CABG) were performed per 1000 women age 45 to 64 in each of the plans. It is helpful to look at the rates of these three heart procedures together. A very high rate of catheterization may indicate that the plan's physicians are not using the best strategy to evaluate a patient with heart disease or that other tests to diagnose heart disease are less available. A very low rate of catheterization may indicate problems obtaining indicated diagnostic tests. If angioplasty rates are very low and CABG rates are very high, this may be due to needlessly invasive treatment. However, if angioplasty rates are very high and CABG rates are very low, then patients may not be receiving optimal care.

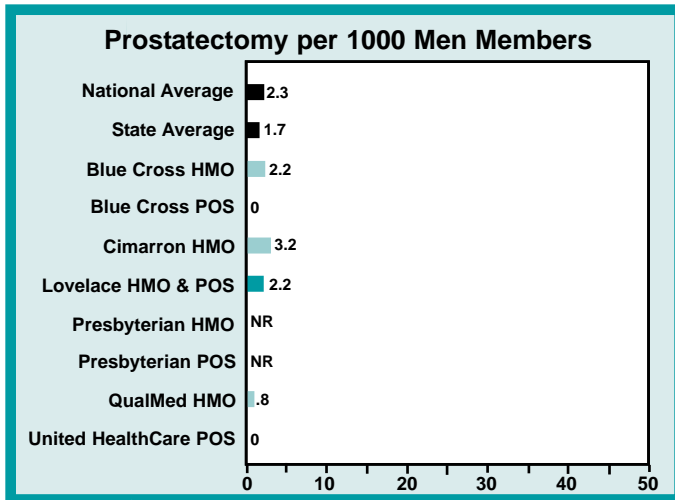


NR = an audit determined the information was not accurate.

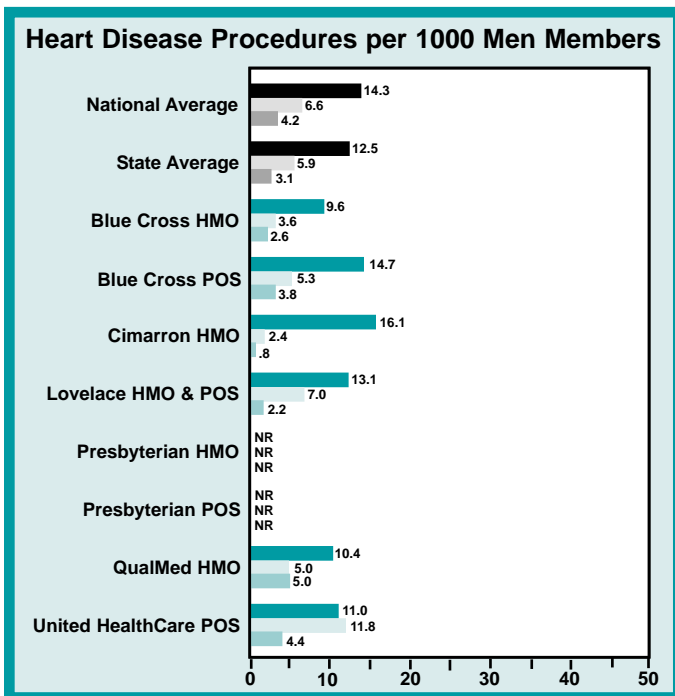
Managing Illness

Information on Surgical Care for Men

How the information on this page is useful in choosing a plan: People may find the information below especially relevant if they or family members experience an illness that requires one of the hospital procedures described below. This information also provides some insight on how each plan manages use of inpatient care. There are many reasons that the frequency a procedure is performed is different from plan to plan, including patient preference, different standards of care, and how healthy members of each plan generally are. Plans can also influence these rates through their policies, financial incentives offered to their physicians and special disease management programs they offer.



The removal of the prostate gland or prostatectomy is the surgical procedure to treat cancer or the problems caused by enlargement of the prostate gland. The chart shows the rate of prostatectomy per 1,000 male members age 45 to 64. Very low rates can indicate barriers to appropriate care. Very high rates also raise concerns about patient involvement and the potential over use of surgery and underuse of alternative treatments.



Common procedures to diagnose and treat heart disease - Three procedures are commonly used to diagnose and treat heart disease. Coronary angiogram (cardiac catheterization) is used to determine the location and severity of heart disease. Angioplasty and coronary artery by-pass graft (CABG) are used to surgically treat coronary artery heart disease. The chart shows how frequently cardiac catheterizations, angioplasty and coronary artery by-pass grafts (CABG) were performed per 1000 men age 45 to 64 in each of the plans. It is helpful to look at the rates of these three heart procedures together. A very high rate of catheterization may indicate that the plan's physicians are not using the best strategy to evaluate a patient with heart disease or that other tests to diagnose heart disease are less available. A very low rate of catheterization may indicate problems obtaining indicated diagnostic tests. If angioplasty rates are very low and CABG rates are very high, this may be due to needlessly invasive treatment. However, if angioplasty rates are very high and CABG rates are very low, then patients may not be receiving optimal care.



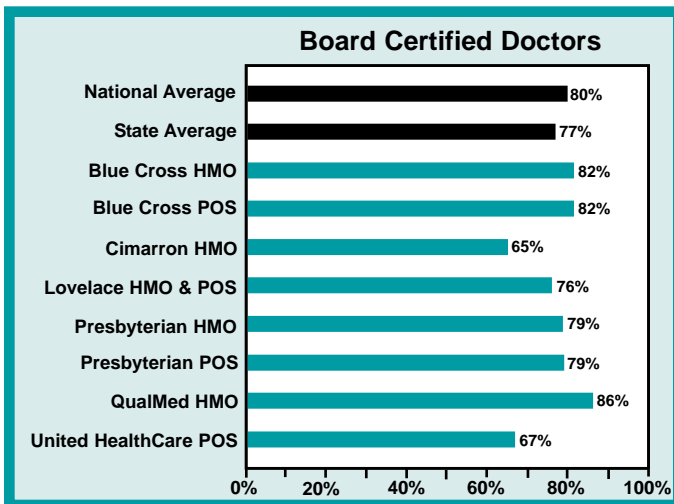
NR = an audit determined the information was not accurate.

General Information

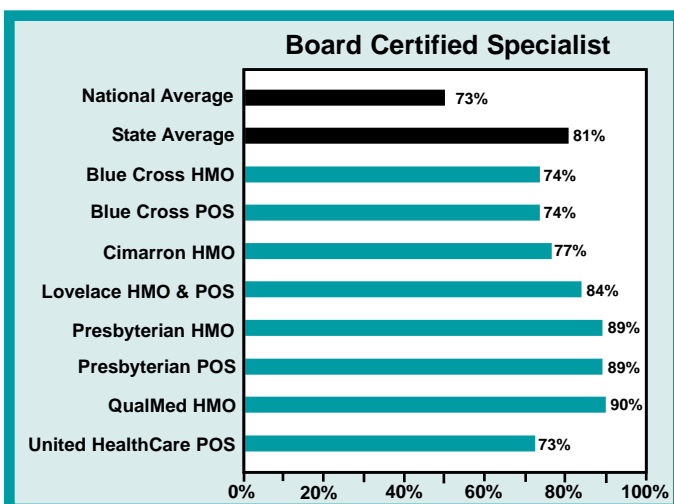
Information about Provider Certification

How the information on this page is useful in choosing a plan: The quality of plan doctors has a significant impact on the overall quality of care delivered to health plan members. The information below can help assess “how good” a plan’s doctors are. Board certification is one of the qualifications you can expect most physicians to have but it is not a requirement to practice medicine.

How each plan measures up: This measure provides basic information on the qualifications of the plan’s physicians. A high rate of physicians and specialists with board certification in each plan may indicate higher standards of care.



A board certified primary care doctor means that the doctor has passed a special exam in their area of primary care. By passing the exam, the doctor has met an expected set of standards set by a national board. The graph shows the percent of board certified physicians in each plan for primary care physicians.



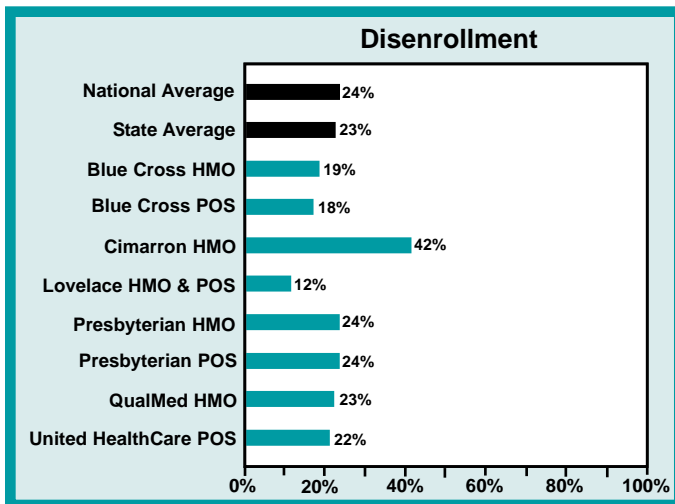
A board certified specialist means the doctor has passed a special exam in their medical specialty. By passing the exam, the doctor has met an expected set of standards set by a national board. The graph shows the percent of board certified specialists in each plan which includes pediatric physician specialists, OB/GYN providers, geriatricians and all other physician specialists.

General Information

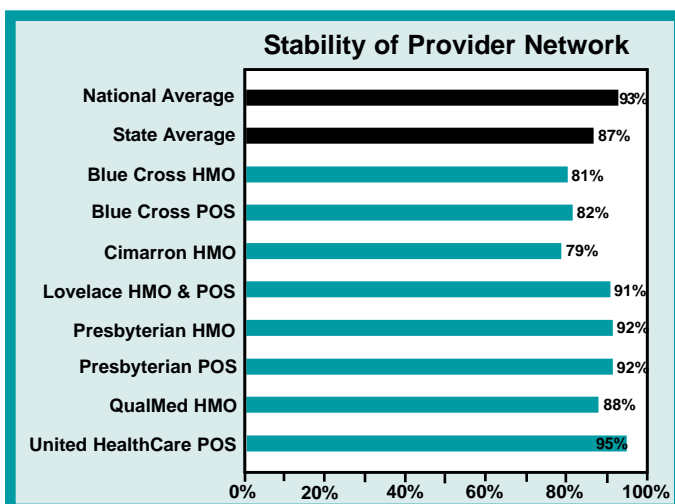
Do Members and Providers Stay with the Health Plan?

How the information on this page is useful in choosing a plan: Members may leave (disenroll from) a health plan because their employer no longer offers it, they are relocating or because of care or service issues. Providers may leave (turnover) if they are dissatisfied with such things as health plan's policies, they are relocating or for other personal reasons. However, providers are sometimes asked to leave when plans consolidate or they do not meet certain standards.

How each plan measures up: Check high rates of disenrollment against the plan results on member satisfaction on pages 8 through 11 to see whether there seems to be a connection between disenrollment and dissatisfaction. A low provider turnover rate ensures patients receive uninterrupted care.



Disenrollment measures the percent of members **who left a plan** during a given time period for voluntary or involuntary reasons. Note that in this chart a lower rate is better.



How stable is the network of providers?

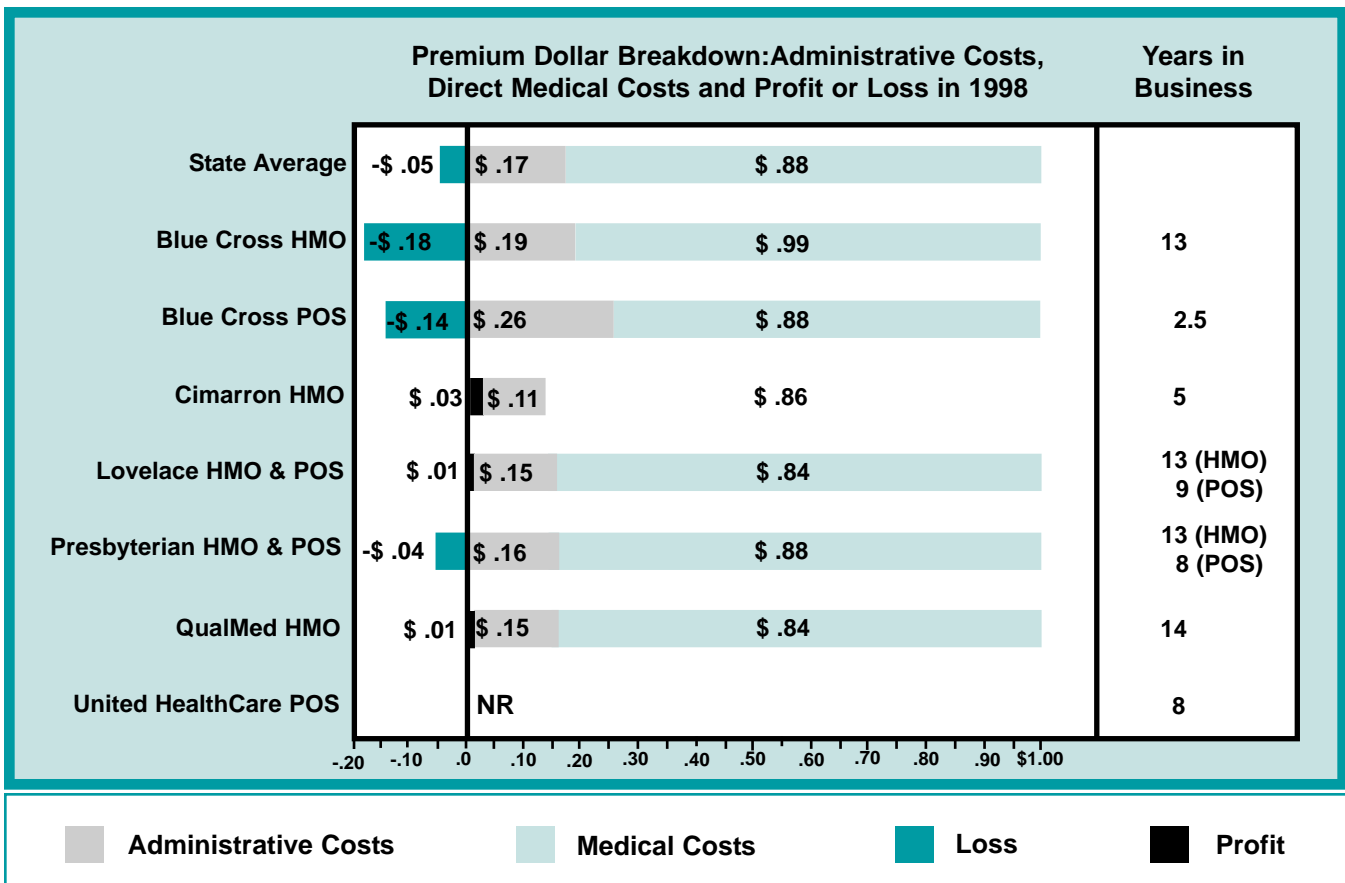
A high turnover rate among the plan's providers can be troubling. This chart indicates the likelihood that primary care physicians **will stay with the plan** over the long term.

General Information

Plan Finances: How the Dollars are Spent

How the information on this page is useful in choosing a plan: Purchasers need to know that a health plan is efficient and stable and how their premium dollars are used. Health plans that have remained in business for a number of years have demonstrated some permanence in a broad sense. Premiums - the amount members pay to the plan for health coverage - go toward administrative expenses as well as direct patient care (such as doctor and hospital bills, lab tests, etc.). Any amount left over is the profit earned by the plan. No profit over several years can be a sign of financial trouble. From another perspective, the more spent on direct patient care the more chance there is that members are receiving services and the administrative operations are functioning efficiently.

How each plan measures up: The chart below can be used to show how your health care dollar is spent by each health plan. Using the state average as an example, 88 cents of each dollar paid in premium goes to pay for direct medical care, while 17 cents goes to administrative cost with a loss of 5 cents overall. Loss, if any, is reported as a negative number. Some differences in the chart, however, may be a result of plans not reporting these costs in a standard way. For example, some plans include administrative nursing staff and medical directors in administrative cost, while others include these in medical costs.



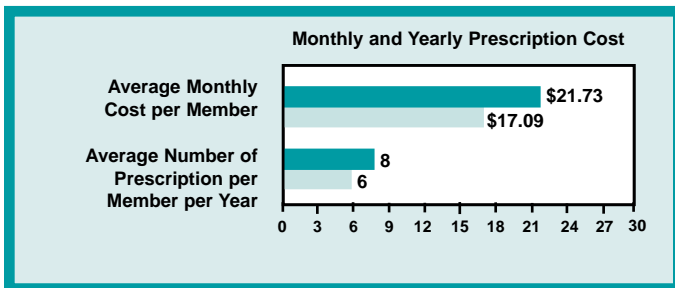
NR = the plan did not report this information

Use of Services

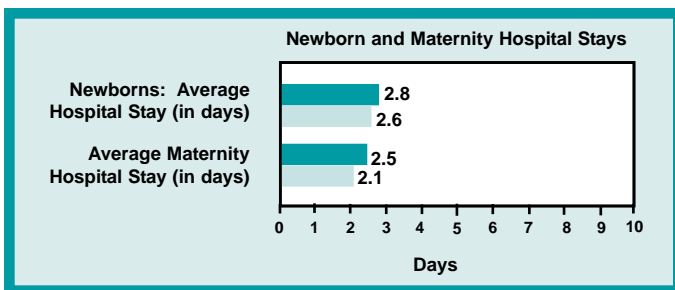
Information on how New Mexico Compares to the Nation

For the information below, health plans within the state reported results that were not very different from one another. Even so, it is useful to compare the overall use of managed care services in New Mexico to the nation. The information can help to identify health issues that the state may need to address. The charts show that in 1998:

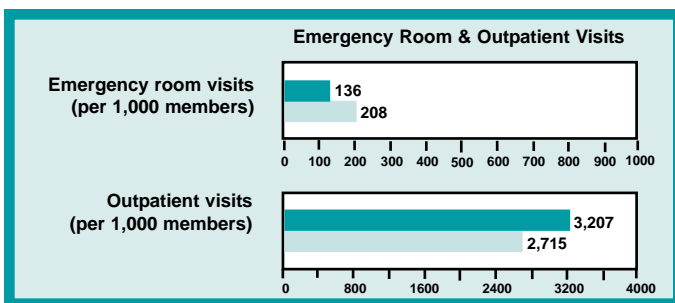
- Per member, New Mexicans use fewer prescriptions and pay almost 25% less per month. *
- After childbirth, mothers around the country stay in the hospital almost a half a day longer than they do in New Mexico.
- Members of managed care in New Mexico used the emergency room more than members in the nation, while they used outpatient services less. This may mean there is inadequate access to primary care, although patient choice also plays a role.



Monthly prescription cost. This chart shows the number and cost of prescription drugs. First, the average monthly cost - including health plan and member costs - of prescription drugs per member for New Mexico and the nation is shown. The second set of bars shows the state and national averages for the number of prescriptions per member per year.



Newborn and maternity hospital stays. This chart shows the number of days all newborns and mothers stayed in the hospital after birth on average for New Mexico and the nation. All deliveries, vaginal and cesarean section are counted.



Emergency room and outpatient use of services. The first set of bars shows the average number of emergency room visits annually per 1,000 members for New Mexico and the nation. Only visits to the emergency room that did not result in a hospital admission are included. The second set of bars shows the average number of outpatient visits patients had with providers, including primary care, specialist care, after-hours care, urgent care and nursing home visits. Mental health and chemical dependency services are excluded.

*The dollars are unadjusted for differences in the cost of living in different states.

Your Rights and Responsibilities

Patient Protection is the Law in New Mexico

Members of HMOs in New Mexico have these Rights:

The right to receive a summary of covered benefits, a list of services not covered, premium information and a provider list.

The right to have reasonable access to health care services.

The right to sufficient types of qualified and adequate numbers of health care providers.

The right to reasonable access to out-of-network health care providers, if medically necessary services are not reasonably available through the plan.

The right to emergency care without prior authorization.

The right to appropriate out-of-network emergency care without additional cost.

The right to a fair and prompt appeal through the Superintendent of Insurance.

The right to covered health care services in a timely manner.

The right for patients with chronic medical conditions to use a specialist as their primary care provider as long as the specialist offers all basic health care services required of primary care providers by the plan.

The right for patients to discuss treatment options with their provider, even if the plan does not cover the option.



The New Mexico Division of Insurance Office of Managed Care and Ombudsman can help.

If you have questions about filing an appeal dealing with your health plan or need more information about **The Patient Protection Act**, call the Office of Managed Care and Ombudsman (505-827-3928 or 1-800-947-4722) to assist you in understanding and upholding your rights.

Complaints and Grievances

A **health plan complaint** can be a concern in which a consumer feels he or she has been treated improperly or did not receive an expected benefit as a health plan member.

The NM Division of Insurance Office of Managed Care and Ombudsman can help.

If you have questions about filing an appeal dealing with your health plan, call the Office of Managed Care and Ombudsman (505-827-3928 or 1-800 947-4722) to assist you. You will be assisted in proceeding through predefined steps in an appeals process.

Where to Start

The first step begins at your health plan. If you have a complaint, contact your health plan customer assistance representative. If you are not satisfied, ask about their complaint process and ask to speak with the Appeals Coordinator.

Managed care organizations are required by the state to have a clearly defined complaint process and to let members know about it in writing.

If you feel your complaint is not resolved after talking to the health plan's representative, you may want to pursue a grievance - that is, an appeal.

The first stage appeal is an informal internal review by the health plan and can include documentation the consumer provides. The health plan must mail the decision to the consumer within a defined period of time along with forms in case a second stage appeal is requested.

The second stage appeal must be requested within 30 days of the decision. It is a formal hearing that includes plan and (optionally) consumer representatives. The hearing must take place and the plan must communicate the result to the consumer within defined time lines. Also, the plan must provide the paperwork and an explanation of how to appeal the decision.

A third stage appeal is made by submitting the proper paperwork within a defined time period to the state Superintendent of Insurance to request an external review and hearing. The Superintendent first makes sure the request meets certain conditions: *

- the consumer must be insured by the plan
- the disputed service or benefit must be covered under the policy
- the first and second stage appeals must be complete
- the required information has been provided by the consumer

The Superintendent will notify the consumer within 21 days whether the request has been approved and assign approved cases to the Independent Utilization Review Board. Members of the board are appointed by the Superintendent and include two physicians and an attorney who are not affiliated with the plan. A hearing is scheduled that the consumer may attend with a representative of their choice. After all evidence is considered, the Superintendent notifies the consumer and the plan of the final decision.

* In urgent situations, as in life threatening situations, a consumer may request an expedited appeal from both the plan and the Office of the Superintendent of Insurance.

Evaluation Form

Please Take a Moment to Evaluate this Guide

1. Are you a member of a commercial managed care plan now? (HMO, POS, etc.) No Yes
2. If you are considering Medicare managed care plans, did this Guide help you find information you needed?
 No Yes
3. Is the information provided in the Guide presented in a useful format?
 Never Sometimes Most of the time Always
4. Is the information provided in the Guide easy to read and understand?
 Never Sometimes Most of the time Always
5. Is this Guide effective at presenting differences in quality?
 No Yes
6. If so, will you use this information in making your choice of health plan?
 No Yes
7. Which information provided in the guide is relevant to your personal health situation?
 Member's Point of View Managing Illness
 Children's Health General Information
 Women's Health Use of Services Comparing NM to the Nation
8. Is there other information that might be added to this guide that would help you make a more informed decision when choosing a health plan?

9. From what source did you receive this publication?
 Employer Senior Organizations
 Public library/Educational Institution Chamber of Commerce
 Managed Care Organization State of New Mexico agency
 Hospital or Health provider Other: _____

Information on **MEDICARE** Managed

Where to go for Information:

In New Mexico the State Agency on Aging provides assistance about Medicare and other health insurance questions. Contact:

New Mexico Agency on Aging
Health Insurance and Benefits Assistance Corps
1-800-432-2080

The Health Care Financing Administration (HCFA) provides extensive information on Medicare's health plan options, including costs, benefits and quality. Locate information on plans that serve your area by accessing the Internet web site:

www.medicare.gov
or by calling Medicare at
1-800-MEDICARE

The state Health Policy Commission has produced a brochure summarizing the information on the quality of New Mexico's Medicare managed care plans for those unable to access the Medicare web site. Ask for the brochure, **Medicare Managed Care, Help in Choosing a Quality Health Plan** when you contact the Commission:

New Mexico Health Policy Commission
(505) 424-3200
2055 South Pacheco, Suite 200
Santa Fe, NM 87505

MEDICARE Managed Care Plans in New Mexico

	Areas Served in 1998 / Counties	Phone Number
Lovelace North	Bernalillo, Los Alamos, Sandoval, Santa Fe, Rio Arriba (partly), San Miguel, Torrance, Valencia, Socorro	1-800-808-7363
Lovelace South	Dona Ana, Otero, Sierra (partly)	1-800-808-7363
Presbyterian /Secure Horizons	Bernalillo, Cibola, Rio Arriba, Sandoval, Santa Fe, Valencia	1-800-797-5343
QualMed*	Bernalillo, Sandoval, Rio Arriba, Valencia, Taos, Torrance, Los Alamos, Mora, Santa Fe, San Miguel	1-800-365-0009 1-505-798-7368

* Effective October 1, 1999, Cimarron Health Plan purchased QualMed.

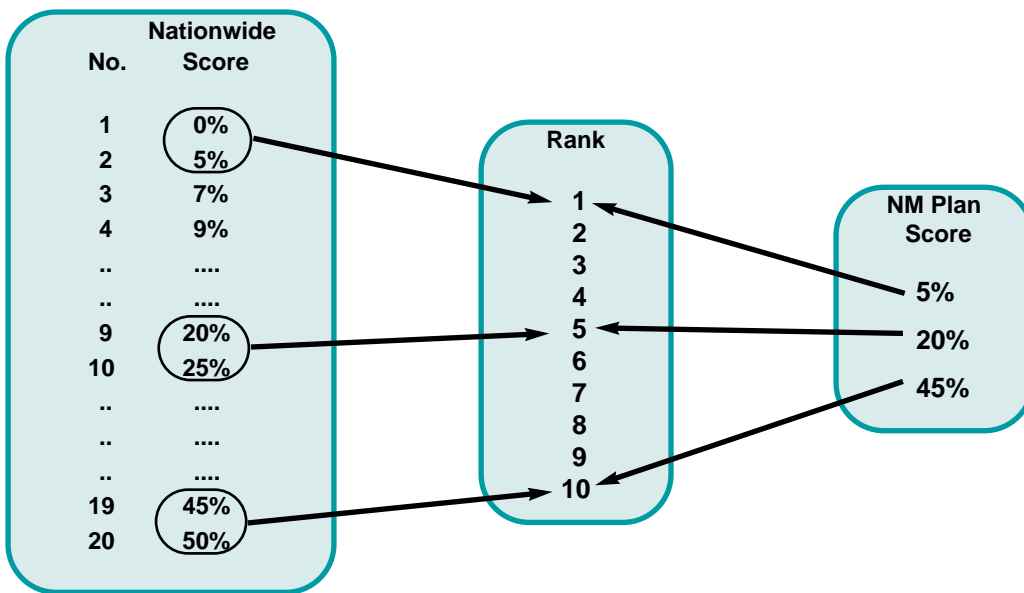
What is Behind the Summary Rankings

New Mexican managed care plan performance was summarized in the tables on pages 6 and 7 by ranking the rate (or percent) each plan scored on performance measures.¹ The purpose of the summary ranking was to provide a fair way for consumers to judge at a glance how managed care plans in New Mexico stand compared to each other and to plans nationwide. A rank of 0 (lowest) to 10 (highest) was used. The performance of plans nationwide provided a standard yardstick by which local plans could be judged, while still allowing consumers to compare plans in our state with each other.²

An artificial example will show how the ranking was done. In the example...

- 20 nationwide plans report 0% to 50% of their members gave them high ratings
- 3 New Mexico plans report 5%, 20% and 45% of their members gave high ratings

How it works. The nationwide plan scores are ordered from lowest to highest. The list is divided into 10 parts or ranks so that each part contains one tenth (10%) of the scores. A calculation provides the boundary scores for each rank.³



The New Mexico (NM) plan rates are then compared to the boundaries to determine the rank. In the example, the New Mexico plan with the score of 20% received a rank of “5”. In other words, half (or 50%) of all plans nationwide ranked lower and half ranked higher. More importantly, the ranking shows one New Mexican plan ranked much lower and the other one much higher.

¹ Plan rates, such as the percent of members who gave their plan a high rating, are reported in the Detail Charts on pages 8 to 23.

² The ranking was based on a nationwide database of all managed care plans that publicly report standard performance data to the National Committee for Quality Assurance (NCQA). In 1999, there were 230 plans that reported member satisfaction survey results and 277 plans that reported clinical measures such as cervical or breast cancer screening rates to NCQA. Half of the New Mexico health plans voluntarily reported these measures to NCQA to be made public.

³ This approach is similar to calculating “percentiles” widely used to report the standing of an individual relative to the performance of a known group. (See E.W. Minium *Statistical Reasoning in Psychology and Education*, 1978).

COMMERCIAL MANAGED CARE PLANS

	Phone Numbers	Areas Served in 1998 / Counties	Number of Members as of 12/31/98	Language Translation Available
Blue Cross Blue Shield:				
Health Maintenance Organization	(800) 423-1630	HMO - All except San Juan, McKinley & Cibola	46,178	No
Point of Service (POS) Plan	(800) 432-0750	POS - All	30,056	No
Cimarron Health Plan				
Health Maintenance Organization	(505) 342-4680 (800) 473-0391	All	7,016	Yes
Lovelace Health Systems:				
Health Maintenance Organization Albuquerque area	(505) 262-7363	All	163,000	Yes
Point of Service (POS)	(800) 808-7363			
Presbyterian Health Plan:				
Health Maintenance Organization	(505) 923-5678 (800) 356-2719	All	53,482	No
State Employees, Point of Service	(888) 275-7737		33,366	No
*QualMed:				
Health Maintenance Organizationafter hours	(800) 365-0009 (505) 798-7368	Bernalillo, Sandoval, Rio Arriba Valencia, Taos, Torrance, Los Alamos, Mora, Santa Fe, San Miguel	29,949	Yes
United HealthCare:				
Point of Service	(800) 782-9883		10,211	Yes

* Cimarron's purchase of QualMed was effective October 1, 1999.

This book is your guide to the quality of managed care plans in New Mexico.

*A health plan's quality can be judged
by how well the plan keeps its
members healthy or treats them
when they are sick.*

Acknowledgments *This publication is the product of the contributions of many individuals. Sincere thanks to the consumer groups, businesses, health care organizations, nonprofit organizations and state agencies that assisted in developing this report, particularly those serving on the Advisory Committee to the Health Policy Commission and the Editorial Board of the Consumer Guide. Their insight, expertise and thoughtful review provided balance in this report to meet the diverse needs of New Mexican consumers.*

This report is available free at our web site at <http://hpc.state.nm.us> or from public libraries.

For additional print copies, contact the Health Policy Commission (505-424-3200). The Commission encourages the reproduction of this report provided that use of comparative information is comprehensive.

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