



Centennial Care Waiver Demonstration

Section 1115 Annual Report
Demonstration Year: 1 (1/1/2014 – 12/31/2014)

March 31, 2015

New Mexico Human Services Department

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Section I: Introduction

Launched on January 1, 2014, Centennial Care places New Mexico among the leading states in the design and delivery of a modern, efficient Medicaid program. Highlights from the first waiver year (January 2014-December 2014) include:

Successful Transition to Centennial Care

- 11 month readiness phase (February-December 2013) proved successful.
- More than 200 educational events conducted statewide from mid-August through November 2013; 59 focused specifically on Native American communities.
- Numerous workgroups established during readiness to address specific implementation efforts.
- Seamless transition of more than 400,000 members on January 1, 2014.
- Command Center established in first few months as a rapid-response strategy to address emergent transition issues.
- Daily meetings with MCO leadership held within the first few months to address provider/member issues and facilitate immediate resolution.
- Daily transition reports submitted by MCOs to monitor implementation and identify critical issues in care coordination, provider reimbursement and call center performance.
- Ongoing meetings held with provider groups to address contracting and reimbursement issues.
- Trainings conducted for MCOs and care coordinators on community benefit package and care coordination requirements.
- Letters of Direction were issued to the MCOs to ensure appropriate transition of specific populations with no interruption in services.
- The Human Services Department (HSD) issued the Centennial Care Policy Manual to ensure consistency among the four MCOs.

New Benefits and Features in Centennial Care

Centennial Care added new behavioral health (BH) benefits to the Medicaid program:

- Recovery services that provide peer-to-peer instruction focused on developing and enhancing wellness and health care practices in a supportive group setting;
- Family support allows a service team to focus on the family and assist with developing patterns of interaction that promote wellness and recovery over time; and
- Respite for youth provides short-term, temporary relief for family members caring for youth with serious emotional disturbances.

Care Coordination

In Centennial Care, all members receive a health risk assessment (HRA) and are placed in an appropriate level of care coordination – level 1, 2 or 3. Those in higher levels of care

coordination (level 2 or 3) receive a comprehensive needs assessment (CNA) to assess physical, behavioral and long-term care (LTC) needs and receive a person-centered care plan.

Care coordination level 2 members receive semi-annual in-person visits, quarterly telephone contact, and an annual CNA to determine if the level of coordination and care plan are appropriate.

Care coordination level 3 members receive monthly telephone contact, quarterly in-person visits and a semi-annual CNA to determine if the level of coordination and care plan are appropriate.

Community Benefit

- Prior to Centennial Care, recipients received HCBS through allocation (aka slots) to the HCBS waiver; approximately 3,043 slots were available in the prior CoLTS C waiver.
- In Centennial Care, all members with a nursing-facility level of care (NF LOC) may receive home and community based services, known as the community benefit package:
 - Prior to Centennial Care, 15,000 recipients received only personal care services; now, they have access to the full community benefit package, including assisted living, environmental modification, respite, private duty nursing, and skilled maintenance therapies.
 - Approximately 20,000 members are currently receiving HCBS.

Community Interveners

Centennial Care allows eligible deaf-blind members to work one-on-one with community interveners. Community interveners:

- Provide critical connections to other people and the environment;
- Open channels of communication between the individual and others;
- Help to provide access to information; and
- Facilitate the development and maintenance of self-directed independent living.

Centennial Rewards Program

- The member rewards program was developed to encourage members to become more active participants in their healthcare.
- In waiver year one (WY1), \$8 million in rewards were earned.
- In WY1, \$600,000 in rewards was redeemed.
- Members earn rewards by making healthy choices, such as:
 - Annual dentist visit;
 - Joining their MCO's prenatal program;
 - Managing asthma through controller refills;
 - Managing diabetes through getting the appropriate tests and examinations; and
 - Managing certain BH conditions through medication refills.

Native American Advisory Meetings

Centennial Care established the Native American Technical Advisory Committee (NATAC), a subcommittee of the Medicaid Advisory Board, to:

- Advise the Medicaid program about how best to communicate with Native American Centennial Care members and how best to work with Indian Health Services (IHS), Tribal health providers and urban Indian providers to facilitate successful reimbursement and to reduce administrative burden; and
- Meet quarterly with Tribal leaders to address issues related to enrollment, access to care and payment for services.

The MCOs are also required to conduct quarterly Native American Advisory Board (NAAB) meetings to address issues related to benefits, access and delivery of services, and other concerns specifically related to Native American enrollees.

Addressing Provider Workforce Issues and Broadening Access to Care

Ongoing initiatives to expand access to care by maximizing scopes of practice for certain provider types include:

- Covering services performed by properly-supervised licensed, non-independent practitioners at particular provider practices;
- Allowing prescribing psychologists to be reimbursed for certain Evaluation and Management codes; and
- Collaborating with the New Mexico Department of Health (DOH) to implement a curriculum for community health workers.

Centennial Care Improvements

- The primary care provider-to-member ratio standard of 1:2000 was met by all MCOs in urban, rural and frontier counties in WY1.
- There has been improved provider access for some specialties (see Access under Section II).
- Telemedicine has expanded to increase access to care to rural and frontier populations.
- HSD has increased involvement with the MCOs' pharmacy and therapeutics (P & T) committees to confirm that MCOs are evaluating and adopting new pharmaceuticals based on clinical and economic value.
- Through the Children's Health Insurance Program Reauthorization Act (CHIPRA) Cycle III grant award received by HSD, the Medical Assistance Division (MAD) developed an on-line screening tool and electronic application submission tool exclusively for the use of presumptive eligibility determiners (PEDs). This system, Yes New Mexico for PEDs (YESNM-PE), is available to PEDs state-wide. It accurately screens individuals (or entire households) for possible Medicaid eligibility and thus access to care; applications are usually processed within 24-48 hours.

- The number of unreachable members continues to decline due to an unreachable member campaign developed by HSD and initiated by the MCOs to include innovative outreach activities.
- Care coordination processes continue to improve through identification of deficiencies during two audits in 2014 conducted by HSD.

Centennial Care Initiatives in Development

- Creation of health homes targeted to persons with chronic conditions.
- Implementation of electronic visit verification that monitors member receipt and utilization of community-based services.
- Payment reform projects for both hospitals and other providers.
- Pilot project with Bernalillo County to connect jail-involved individuals who are being released with Medicaid and care coordinators in the Centennial Care program.

Section II: Summary of Quarterly Report Operational Issues

Annual Budget Neutrality Monitoring Spreadsheet

The annual budget neutrality monitoring spreadsheet for waiver year one is included in this report as Attachment A.

Health Care Delivery System Update

Benefits

There were no changes in Medicaid covered services or benefits during the first demonstration year. In addition to Medicaid covered services, the MCOs are permitted to provide value added services (VAS) to their members, which must be approved in writing by HSD. MCOs may also offer VAS to members who receive the alternative benefit plan (ABP). See Attachments B and C, Value Added Services 2014 and 2015.

Enrollment

Centennial Care enrollment has continued to increase each quarter during the first waiver year. Expansion of Medicaid eligibility has greatly contributed to the increase in enrollment. The majority of Centennial Care members are enrolled in Population 1-TANF with Related. Population 6-Group VIII (expansion) is the next largest group.

Disenrollment

HSD has addressed sporadic and isolated disenrollment of Centennial Care members that occurred in the first waiver year. This was caused by the implementation of new modified adjusted gross income (MAGI) rules as required by the Affordable Care Act (ACA), the surge of applications due to the expansion of Medicaid eligibility, and the implementation of New Mexico's new eligibility system ASPEN (Automated System Program and Eligibility Network). As described in previous quarterly reports, a short-term fix was applied to immediately address the issue until the long-term fix was implemented. HSD continues to run the file for the short-term fix process as validation to ensure that the long-term fix was successful.

Grievances and Appeals

A total of 2,668 grievances were filed by all Centennial Care members in the first waiver year. Member grievances were tracked quarterly for each MCO by reports per 1000 enrolled members.

Table #1. Member Grievances

WY1 Quarter	Grievances per 1000 Enrolled Members			
	BCBSNM	MHP	PHP	UHC
Q1	1.20	.15	1.46	2.62
Q2	1.41	.21	1.43	3.49
Q3	1.83	.19	1.65	4.28
Q4	.51	.22	1.41	3.73

MCOs reported a combined total of 1,693 grievances within the top three types of grievances. The top three types of grievance categories reported were:

1. Ground transportation non-emergency
2. Primary Care Physician
3. Other Specialists

Issues with non-emergency ground transportation grievances was the largest number of grievances reported. Transportation concerns included late and/or no pick-ups for scheduled appointments and return trips, rude drivers, unsafe driving by drivers, drivers requesting gas money from members, and injuries during transport. MCOs responded to the concerns by working closely with their transportation vendors through increased meetings, providing direction to their vendors and by implementing action plans as needed.

Table 2 below illustrates the additional types of grievances reported by MCO within the top three types.

Table # 2. Types of Grievances

Grievance Type	Number Reported	Percentage Reported
Ground Transportation Non-Emergency	1,006	59%
Primary Care Physician	198	12%
Other Specialties	134	8%
Emergency Room	87	5%
Dental	80	5%
Vision	45	3%
MCO Operational Issues	27	2%
Inpatient	26	2%
Provider Specialists	20	1%
Durable Medical Equipment	18	1%
Personal Care Options, Adults	13	1%
Urgent Care	12	1%
Care Coordination	12	1%
Behavioral Health	7	0%
Laboratory	6	0%
Pharmacy	2	0%

Primary care physician (PCP) grievances were reported as issues of rude staff or providers. Other specialist grievances were largely issues of members requesting pain medications that providers were unable to determine as medically necessary, or grievances were related to service delivery. Emergency room (ER) grievances were due to dissatisfaction with ER staff and long wait times. Dental concerns were related to not being approved for dentures or braces. MCOs addressed these issues through their internal processes in a timely manner. The other 11 types of top three

grievances constituted less than 3% of any individual type reported. No additional trends have been evidenced in any of these other areas.

A total of 1,764 appeals were filed by Centennial Care members in the first waiver year. Of the total appeals filed, 1,101 (62 percent) were upheld, 430 (24 percent) were overturned and the remainder, 233 (14 percent) were still pending resolution at the end of the year. All MCOs have processed appeals in a timely manner.

Denial or limited authorization of a requested service was 1,552 (88 percent) of all appeals. Trending by MCOs identified that some providers needed additional education in this area. The MCOs completed outreach and training for these providers. No other specific trends were identified in this area or within the remaining 663 appeals (12 percent).

Quality of Care

Please refer to Section VI for information related to quality of care.

Access

All MCOs far exceeded the PCP-to-member contractually required ratio of 1:2000 in 2014. The ratios ranged from 1:15 to 1:102 in December. The PCP-to-member ratio is calculated as of the last day of the reporting period, and calculated by dividing the total number of non-dual members by the total number of PCPs. Dual-eligible members are excluded from the calculation because a dual-eligible member has a PCP through Medicare. Open PCP panel slots for new patients range from 80-92 percent depending on the MCO. There were no identified PCP ratio concerns in 2014.

Geographic access to hospitals, primary care physicians, pharmacies, dentists and most specialty providers were met in the urban, rural and frontier counties. Molina Healthcare of New Mexico (MHNM) did not meet the geographic standards for federally qualified health centers (FQHCs) in rural areas, specifically Lea and San Juan counties. However, these members have 100 percent access to rural health clinics (RHCs). MHNM reported that it contracts with an FQHC in each of the counties. MHNM attributes the low geographical access percentage to the majority of members living greater than 60 miles from the facilities. HSD will investigate and provide an update on this situation in the first quarter of 2015.

A statewide enrollment challenge continues for all MCOs in the area of dermatology. Some MCOs are recruiting out-of-state border area specialists, especially in dermatology. In rural and frontier areas, MCOs have met with varied success in contracting hematologists/oncologists, endocrinologists, rheumatologists and neurosurgeons. New Mexico has several health provider shortage areas. In some instances, the population, and the number of residents requiring specialty services, may not be sufficient for a provider to establish and/or sustain a specialty practice. In instances of provider shortages, the MCOs utilize non-medical

transportation with meals and lodging as necessary, telemedicine, and single case agreements to ensure that the members who require medically necessary services receive them. Ongoing dialogue continues with the MCOs stressing the importance of meeting all geographic access requirements.

MCOs continue their efforts to recruit and contract new providers as well as focus on retention and provider satisfaction. MCO provider satisfaction survey reports are due to HSD at the end of March 2015. Blue Cross Blue Shield of New Mexico (BCBSNM) uses Strennus Network360[®] Market Analysis Report to identify available physical health (PH) and long-term care (LTC) providers within New Mexico and in border areas. United Healthcare of New Mexico (UHC) is contracting with Covenant Medical Group, a large provider group in Texas with a New Mexico presence. UHC is closing service delivery gaps by collaborating with Lovelace Medical systems to deliver pulmonology services to critical care patients living in rural communities. Telemedicine physicians use secure connectivity and blue tooth stethoscope technology to provide comprehensive clinical care for patients living in remote access communities.

Beginning in January 2015, a telemedicine clinic is starting with pulmonology patients in Roswell and will expand to other remote locations and additional sub-specialties. UHC is looking at the Las Cruces area as the next expansion location for pulmonology. UHC began discussions for the next targeted subspecialty and is likely to select neurology. UHC is also introducing teledermatology consultations using asynchronous telemedicine. UHC contracted with the Teledermatology Company to work with the New Mexico Primary Care Association (NMPCA) and FQHC PCPs to have them sign up for services. Teledermatology uses a store-and-forward form of telemedicine to provide dermatology consultations for PCPs. Teledermatology is currently reaching out to PCPs to let them know about the services it provides. Services are available statewide.

MHNM identifies, recruits, and helps to implement new (distant site) healthcare providers and new (originating site) patient care locations serving rural and frontier members. When a distant site provider or originating site is identified, MHNM offers a three-step startup support process: a technical readiness review is conducted to assure that the location(s) are technically ready to provide or receive telemedicine services; MHNM reimburses the new telemedicine provider or originating site for one year's cost of secure cloud-based telemedicine service; and, user training on the cloud-based telemedicine service is provided. In addition, MHNM provides an ad-hoc referral service, matching known locations in need of services with known providers of those services via telemedicine.

Presbyterian Health Plan (PHP) has a comprehensive provider network and is the only MCO with an employed provider group as well as a contracted provider network. Where any shortfalls

of providers exist, telemedicine is being studied as an alternative for members residing in rural and frontier areas.

When evaluating access, HSD also examines the MCO grievances and appeals reports for insight into member concerns. The quarterly reports did not reveal access issues except in the area of transportation (see Transportation section below) and wait times at the ERs. It should be noted, however, that grievances regarding ERs include other issues aside from wait times, including complaints about staff, and only represented five percent of grievances overall. MCOs are incentivized annually to reduce ER utilization for non-emergent conditions. With additional improvements in the second year and a focus on system-wide collaborative practices, HSD anticipates a reduction in wait times, a decrease in associated grievances, and further reduction in ER costs as compared to levels seen early in the demonstration.

HSD will receive the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data in June 2015 and will further evaluate member experiences related to access. HSD will also receive MCO provider satisfaction survey reports which will give insight into provider concerns. These metrics are all being monitored by HSD.

BH Workforce Development

Several initiatives are being implemented to expand the BH workforce capacity in New Mexico.

HSD recognizes the need for additional clinicians in the BH network, and the need for improved services to members by quality supervision and training of staff, especially those who have not yet attained independent licensure. To streamline that process, HSD:

- Issued Supplement 15-01 to the *NM Medical Assistance Program Manual* related to billing instructions for several Medicaid specialized BH services that clarifies billing for non-independently licensed practitioners;
- Will soon begin enrolling non-independent providers so that they may be properly identified on a claim as a rendering provider; and,
- Has developed draft policy and procedures to allow for services to be provided and billed by supervised non-independently licensed (NIL) BH practitioners across all BH organizational types.

Other activities to address BH workforce development include:

- The BH Collaborative adopted recommended changes to the state's definition of seriously emotionally disturbed (SED) youth that now recognizes complex trauma as a component.
- In support of the New Mexico Children, Youth and Families Department's (CYFD) "Healthy Transitions" federal grant, HSD developed a memorandum of understanding with CYFD to support the transition of young persons from the CYFD delivery system to

the adult service system. HSD's Office of Peer Recovery and Engagement (OPRE) will encourage the use of peer recovery services and the role of peer specialists in that program.

- As a strategy to support expanding capacity to provide BH services, HSD facilitated training by the American Group Psychotherapy Association for independently licensed clinicians in the provision of group psychotherapy. Designed as training-of-trainers events, over 30 clinicians participated and received their trainer certification. A follow-up evaluation will identify how effective the modality has been in extending access to services and reducing wait times for care.
- Molina began to look at ways to help further extend access to peer support and other wellness related services by adding Wellness Centers to its value added services. HSD will ensure that the other MCOs are aware of this and encourage them to consider similar actions.

Pharmacy

All MCO pharmacy networks met access standards for urban, rural and frontier areas. The MCOs have an expansive pharmacy network including many 24-hour access pharmacies. Each continually reviews provider listings for new pharmacies with which to contract. For example, MHNMM's pharmacy enrollment has increased with an additional 16 pharmacies contracted in the fourth quarter.

Long-Term Care (LTC)

All MCOs met the access standard for both delegated and directed personal care service (PCS) agencies and nursing facilities (NFs) in the fourth quarter. None of the MCOs met the established standard for assisted living facilities (ALFs) in rural areas, but there was some improvement reported during the year. PHP did not meet the standard in urban areas for ALFs, and MHNMM did not meet the standard in frontier areas. It is important to note, however, that in the GeoAccess calculation methodology all members are included in the member-to-provider ratios, though not all members will require ALF services. There is not a high utilization of ALF services, and the network is adequate to meet the needs of the members requesting services. HSD continues to work with the MCOs regarding strategies to encourage providers in all regions to join the pool of Medicaid-enrolled providers.

UHC continues to monitor the State's agency-based community benefit (ABCB) approved provider list to compare it with the UHC network in order to identify possible new providers for its network. UHC reported that it was able to add a total of six new ALFs this year, which improved its access percentages. MHNMM monitors its network carefully in order to identify network gaps. MHNMM has safeguards in place to ensure that members receive medically necessary services. PHP has formal quality improvement processes to address access and availability outcomes. Measures directly impacting immediate member needs and safety are monitored continuously by network management staff for immediate action as needed.

Transportation

BCBSNM and UHC contract with Logisticare for non-emergency ground transportation, and both met the access standard for urban and rural areas in the fourth quarter. UHC did not meet the standard in frontier areas. While geographical access to transportation improved for these MCOs, reports of complaints and grievances against Logisticare have been numerous (see Grievances and Appeals). In December, UHC's total number of grievances began to decrease while BCBSNM's number of complaints increased. HSD has been working with both BCBSNM and UHC to identify causal factors and to set goals and establish timelines for improvement. Effective interventions in improving service and reducing complaints are being identified, and a reduction in complaints is expected.

BCBSNM is working with Logisticare to secure additional contracting arrangements for rural and frontier counties. BCBSNM is also working with transportation providers who may provide transportation in some of the more remote areas. Network development efforts in the rural areas include a focused effort to identify potential transportation providers that are community-based and recruit them into the network as Logisticare transportation providers. HSD has scheduled a meeting with BCBSNM in the first quarter of 2015 to specifically discuss performance improvement and access concerns.

Other

Autism Services

During the first year of Centennial Care, a team of advocates, educators, State personnel, and MCO leaders formed the Autism Care Coordination Council (AC3). The team met every other week, focusing on clarifying the role of care coordinators in understanding members' needs, and their role in helping to meet those needs. The AC3's work also focused on the upcoming revision of the rule (NMAC 8.321.2.10) that expands services in New Mexico to include three stages of services for members diagnosed with or at risk of developing autism spectrum disorder (ASD).

The new rule expanded the age limitation to members under 21 years of age, included the use of applied behavior analysis (ABA), and expanded the provider requirements to include behavior analyst certification board (BACB®) qualifications. The proposed rule was presented at a public hearing in February 2015 and will go into effect 30 days after all comments have been considered and applied. Once it goes into effect, AC3 will begin the work of operationalizing the billing instructions and fee schedule and building the provider network.

Billing for Behavioral Health Services

To address global provider billing issues, two events were conducted in 2014. HSD hosted a one day event for Core Services Agencies (CSAs) to meet face-to-face with the MCOs' claims adjudication staff. CSA teams were encouraged to bring specific questions and documents to the meeting to resolve billing issues. A few weeks later, a state-wide training was brought to four locations where hospitals, independent providers, and smaller agencies met with the MCOs.

Prior to the delivery of the training, the four MCOs and HSD staff worked together to develop training based on global issues and specific concerns of providers during the first year of Centennial Care. The training was designed for WebEx and onsite attendance. Locations throughout the state were carefully considered to meet the needs of providers in both rural and urban areas.

The trainings were held in December 2014 in Albuquerque, Las Cruces, Roswell, and Las Vegas, New Mexico. The trainings included time for providers to meet individually with leaders in the MCOs' claims offices to discuss coding and billing concerns. HSD is monitoring outcomes and will provide updates in subsequent quarterly reports.

Dental

Regular preventive dental care, early diagnosis and treatment can help avoid ER visits and more costly dental problems which may develop, or be worsened, by lack of basic preventive care. Fourth quarter MCO reports show that the preventive dental services are in the top 10 dental services, based on number of paid claims, for both children and adults. In addition, the most rewards earned in the Centennial Rewards program were due to child preventive dental services, followed by adult preventive dental services.

Pharmacy

During the first waiver year, BCBSNM reported pharmacy costs as a key driver in the increased utilization of high-cost specialty pharmacy products. This included products to treat hepatitis C and oncology diagnoses. Other MCOs also reported increased utilization of high-cost hepatitis C drug treatments. Such treatments can last from twelve to twenty-four weeks and, as shown below, can vary in cost between \$17,948.08 and \$31,563.00 (average cost per claim). It should be noted that there may be several claims for one member over the course of treatment. HSD estimates that cost per individual is just under \$90,000.

Table #3. Hepatitis C Drug Utilization (Sovaldi, Harvoni & Olysio), 2014

Sovaldi 400 MG NDC # 61958-1501-01				
	PHP	MHNM	BCBSNM	UHC
Total Number of Paid Claims	59	35	181	74
Average Cost/Claim	\$ 28,421.41	\$ 17,948.08	\$ 28,379.06	\$ 29,014.09
Average Cost/Month	\$ 139,738.58	\$ 62,818.27	\$ 428,050.83	\$ 195,185.73
Harvoni 90 MG/400 MG NDC# 61958-1801-01				
Total Number of Paid Claims	12	25	25	0
Average Cost/Claim	\$ 27,979.67	\$ 31,563.00	\$ 31,328.76	\$ -
Average Cost/Month	\$ 167,878.00	\$ 263,025.00	\$ 261,073.00	\$ -

Olysio 150 MG NDC# 59676-0225-28				
Total Number of Paid Claims	6	0	31	20
Average Cost/Claim	\$ 21,368.00	0	\$ 23,887.66	\$ 25,721.05
Average Cost/Month	\$ 32,052.00	0	\$ 105,788.22	\$ 64,302.63

Source: [MCO] Ad hoc reports, January 9, 2015

MCOs provide generic medications when available. Based on the percentages of generic utilization, there are no identified concerns with over-utilizing brand name medications at this time (see Table 4, below). The hepatitis C treatments listed in Table 3 above are not currently available as generic medications.

Table #4. Generic Medication Utilization, Year-to-Date, 2014

MCO	Generic medication	Brand, generic available	Brand name only
BCBSNM	86.5%	0.3%	13.2%
UHC	87.2%	0.4%	12.4%
MHNM	88.1%	0.2%	11.7%
PHP	87.2%	0.2%	12.6%

Source: [MCO] Report #44, December 2014

Nursing Facilities (NFs)

At the beginning of the demonstration, MCOs took steps to address NF LOC determination turnaround times (TATs). HSD's Managed Care Policy Manual identifies the required turnaround time for determination as "five business days of receiving a completed packet."

By the end of the fourth quarter, PHP reported 99 percent compliance, an eight percent increase since the close of the third quarter. MHNM reported a 90 percent compliance rate by the end of the fourth quarter, an increase of seven percent from the third quarter. BCBSNM reported a 96 percent compliance rate, a one percent decrease from third quarter. Lastly, UHC reported a 95 percent TAT compliance rate, up from prior quarters. HSD has safeguards in place which ensure that if a determination exceeds the required TATs, the member continues to have access to care pending a determination.

HSD also monitors timely claims processing to ensure payment to NFs. After one-on-one trainings to MCOs by HSD in August for processing crossover claims, HSD has not received any further complaints from providers.

Over the year, there were five NF LOC determination appeals. MHC did not have any appeals. BCBSNM had one appeal that was overturned. PHP had two appeals and both were pending at

the end of WY1. UHC had two appeals, one is pending and one was overturned. HSD monitors all appeals to identify patterns or trends.

Amendments

There were three amendments to the Centennial Care MCO contracts in the first waiver year. A third amendment was signed in December 2014 (see Attachment D – Centennial Care Contract Amendment #3).

Community Interveners

The Community Outreach Program for the Deaf – New Mexico (COPD-NM) began providing Community Intervener support to Centennial Care members in August 2014. During the first waiver year, COPD-NM provided community intervener support to seven members. Three of the seven are UHC members, three members are with BCBSNM, and one member has Centennial Care through PHP.

As more deaf and blind individuals are identified and are eligible for Centennial Care, finding qualified community interveners will be a challenge. COPD-NM and the MCOs are working with local connections in communities to find potential candidates.

Care Coordination

The MCOs are required to report their efforts to locate members in need of completing the HRA and CNA. Efforts have included more unannounced face-to-face visits, claim reviews, and engagement of patient-centered medical homes (PCMHs), PCPs, and community partners to assist with locating members. HSD monitors and tracks weekly and monthly progress by MCO (see Table 5, Unreachable Member Campaign). Members who are unreachable do not lose Medicaid eligibility due to their unreachable status.

Table #5. 2014 Unreachable Member Campaign

	October				November				December			
	Baseline	5% Target	Reached	Percent Improved	Baseline	5% Target	Reached	Percent Improved	Baseline	5% Target	Reached	Percent Improved
BCBSNM	9,705	485	524	5.40%	8,722	436	443	5.08%	8,321	416	141	1.69%
UHC	33,312	1,666	2,757	8.28%	44,040	2,202	11,722	26.62%	35,642	1,782	2,009	5.64%
MHNM	32,561	1,628	6,668	20.48%	35,618	1,781	2,032	5.70%	32,874	1,644	4,867	14.81%
PHP	112,957	5,648	6,766	5.99%	71,243	3,562	5,260	7.38%	66,719	3,336	11,144	16.70%

HSD’s Care Coordination Unit provides education and training to internal and external stakeholders regarding the importance of care coordination. A recent training was held for all PCS providers regarding care coordination and its relevance to members receiving such services.

Electronic Visit Verification (EVV)

Due to difficulties encountered by the MCOs in contracting with an EVV vendor, the implementation of EVV was delayed. Once the vendor was on-board, additional unanticipated delays occurred due primarily to system enhancements requested by PCS providers. The MCOs are currently under a corrective action plan to address pending issues. See Attachment E –EVV Corrective Action Plan (CAP). The EVV project is currently making significant progress and objectives are being achieved.

Health Plan Contract Compliance and Financial Performance Relevant to the Demonstration

In the first waiver year, HSD developed a process to implement sanctions related to untimely and inaccurate report submissions as defined in its agreement with the MCOs. HSD expects to finalize sanction amounts for the first nine months of the program and execute notification during the first quarter of 2015.

Participant-Centered Planning and Service Delivery

As detailed in the fourth quarter report, in December 2014, three “listening sessions” were conducted to provide an opportunity for HCBS members and/or advocates to voice their concerns. HSD has taken the actions necessary to address the issues by making revisions to its MCO policy manual.

Self-Directed Community Benefit (SDCB)

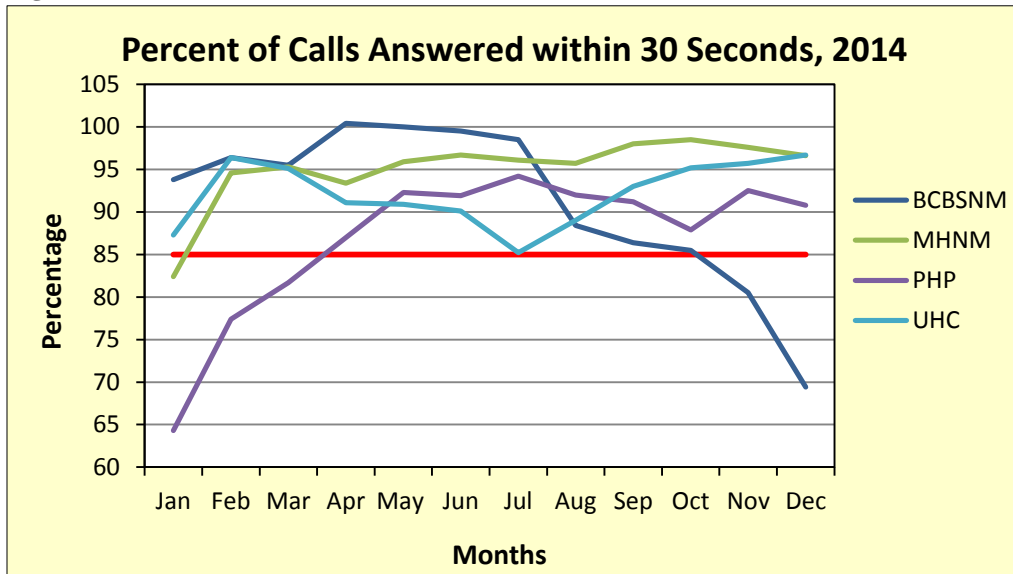
With the implementation of Centennial Care, there were several changes to self-directed services. Members successfully transitioned from Mi Via to the new Centennial Care SDCB. HSD staff worked closely with the MCOs, the fiscal management agency (FMA), support brokers and participants to ensure that care plans were renewed, providers were enrolled and paid, and participants understood programmatic changes.

Call Center Metrics

MHNM, PHP and UHC all met or exceeded contract standards for all customer service and advice lines from September through December 2014. This included contract standards for speed of answer, abandonment rates and call back turnaround times.

Figure #1 below shows the percent of calls answered within the contractually required 30 seconds.

Figure #1. Percent of Calls Answered Within 30 Seconds for WY1



Source: [MCO] Report #2, December 2014

BCBSNM indicated contract metrics were not met due to staffing issues related to higher call volumes and longer wait times during the flu season; however, a decline in performance can be identified as early as July/August. To ensure contractual requirements, BCBSNM addressed the issue by adding staff, incentivizing overtime, and limiting staff absences. HSD directed BCBSNM to anticipate spikes in call volume due to seasonal events and prepare to increase staff when unexpected health events arise. Contract standards were met for all other BCBSNM customer service lines from September through December.

Adverse Incidents

HSD operates a web-based critical incident (CI) reporting system to receive, track and trend critical incidents for the HCBS population and for recipients receiving BH services. Centennial Care providers of HCBS, LTC, and self-directed services are required to report incidents into the system within 24 hours of knowledge an incident. Providers and MCOs are also directed to report incidents involving Abuse, Neglect and Exploitation (ANE) to New Mexico Adult and Child Protective Services (APS).

Initially, MCOs reported CI data to HSD on a monthly basis for HSD monitoring. On a quarterly basis, the MCOs provided a qualitative analysis of critical incidents and their actions in response to such incidents. By the third quarter, it was determined that one quarterly report would be established to capture all the relevant data and analysis. HSD reviews the submitted reports to verify the accuracy of the data and to ensure HSD has a comprehensive picture of critical incidents across the four MCOs.

During the first waiver year, HSD engaged in the following activities to ensure effective CI reporting.

- HSD staff conducted daily reviews of incidents submitted in the web based system. HSD contacted the MCOs with any concerns or issues for follow-up.
- A critical incident workgroup was established and meets on a bi-weekly basis. The workgroup includes representatives from HSD, the MCOs, and other parties as necessary to discuss issues and concerns about the process of reporting. Issues addressed by the workgroup in 2014 included:
 - Clarification on reporting process for BH providers;
 - Clarification on HSD’s follow-up process;
 - Training materials;
 - Duplicate reports;
 - Clarification on the requirement to report within 24 hours;
 - System changes; and
 - High ER utilization.
- HSD staff review all reports of deaths on a monthly basis. HSD nurses review complicated cases. The MCOs are required to provide any information that is missing from the incident notes. The HSD medical officer is available to consult on mortality and complex cases.
- HSD staff respond to requests for password creation, password reset, troubleshooting of application issues, deleting duplicate reports and other business and operational tasks to assist those required to report timely.

Use of the web-based system exhibited growth throughout 2014 as shown in Table 6 below.

Table #6. WY1 Critical Incident System Activity

Quarter	# of Statewide Users	# of CI Reports
Quarter 1	1,000	2,138
Quarter 2	1,500	2,170
Quarter 3	2,307	2,874
Quarter 4	2,300	2,608

See Attachment F. for the total number of CIs reported by type in WY1. HSD tracks incidents by MCO and by CI type, including; BH, self-directed, PH/LTC and fee-for-service (FFS).

Action Plans

The MCOs were effective and proactive in identifying issues and initiating steps to address contract deficiencies and non-compliance during the first year of Centennial Care. Across all MCOs, there were 44 plans implemented and 25 were successfully closed. There are 19 that remain open by the MCOs; however, MCOs and HSD have jointly monitored the progress made

and improvement has occurred in these areas as evidenced by quarterly reporting. MCOs have established baselines, goals and timelines and are closely monitoring any impact on members and providers to ensure continuity of care.

Evaluation Activities

During waiver year one, demonstration evaluation activities were primarily related to selecting and contracting with an evaluation vendor.

- The Evaluation Design Plan was submitted to the Centers of Medicare & Medicaid Services (CMS) for approval in December 2013.
- HSD began its search for an independent entity to carry out the evaluation using the CMS approved Evaluation Design Plan as a guideline to ensure that Centennial Care is meeting its goals. A request for proposals (RFP) was issued Friday, April 18, 2014 and closed on Thursday, May 29, 2014. HSD received two responses to its RFP by the deadline.
- The selected offeror was informed of being selected for tentative award of a contract to evaluate Centennial Care.
- CMS provided HSD with a formal acceptance letter of the Evaluation Design Plan in October 2014.
- HSD continued contract negotiations with the selected vendor. At the end of the waiver year, HSD was in the procurement process and no public information had been released regarding this tentative award. The contract was signed in February 2015 and HSD began meetings with the vendor to develop a work plan. An update will be provided in the next quarterly report.

Quality Assurance Monitoring Activities

HSD reviewed all service plan reduction requests for the first six months of Centennial Care. In that period, HSD approved two of seven requests for reduction in service plans due to members no longer meeting the requirements for the services. HSD will continue to conduct an annual review of a valid representative sample of service plan reductions for transitioning members.

HSD continues to review high NF LOC and community benefit NF LOC denials on a quarterly basis to ensure the denials are appropriate and based on NF LOC criteria. No concerns were identified in 2014.

Table #7. WY1 NF LOC Reviews

High NF LOC denied requests (and downgraded to Low NF LOC)	2014 Totals
Number of member files audited	104
Number of member files that met the appropriate level of care criteria	104

Percent of MCO level of care determination accuracy	100 percent

Community Benefit denied requests	2014 Totals
Number of member files audited	119
Number of member files that met the appropriate level of care criteria	119
Percent of MCO level of care determination accuracy	100 percent

HSD conducts monthly audits of each MCO to ensure the appropriate implementation of community benefit service plans. HSD reviews a representative sample of service plans from each MCO to ensure that the MCOs are appropriately allocating time and services identified in each member’s CNA, and that the member’s goals are identified in the service plan. A key component of this audit is the review of the allocation tool used to determine community benefits.

With feedback from HSD during the first waiver year, there has been a steady increase in properly completed allocation tools; thus, ensuring that service plans meet members’ needs. In December 2014, more than 97 percent of all audited allocation tools were completed correctly.

Post Award Forum

The Centennial Care post award forum was held on Monday, June 16, 2014 as part of a regular Medicaid Advisory Committee (MAC) meeting. Seventy-seven people attended the meeting (all MAC meetings are open to the public). Medicaid Director, Julie Weinberg introduced the discussion, and explained the purpose and the intent of the forum – to hear public comment about the implementation of the program.

MAC members provided input on such issues as:

- Difficulty with the new categories of eligibility.
- Delays in completing applications.
- Recipients being erroneously dropped from eligibility.
- Difficulty with finding information on the HSD website.
- Low payments to providers, especially for BH services.

- Policy issues needing to be resolved.
- Unsure of roles in care coordination.
- Appeals are processed as grievances and not channeled into the fair hearings process.
- Provider credentialing is an eight-month process.
- There is more focus on adult chronic care versus children.

On the positive side, MAC members stated:

- There is good rapport and relationships with MCOs.
- They have appreciation for HSD staff willingness to help and provide support.
- They are pleased the mandatory coverage of Naloxone kits.
- They are pleased with the new Centennial Rewards program.

Overall, MAC members felt that there were difficult aspects of Centennial Care, however, agreed that it is improving. They urged HSD for continued partnership, requested that they “be at the table”, and said that they are looking forward to the full implementation of the Independent Consumer Support System.

A sign-in sheet was provided to organize the public comment period. There was no time limit for commenting. A total of 15 consumers, providers, and advocates, including Native American and LTC providers and advocates, commented on their experiences since Centennial Care was implemented. The issues that were raised included:

- Lack of useful information or data about Centennial Care.
- Shortage of care coordinators.
- Better training is needed for care coordinators.
- Member disenrollment issues with the SDCB program.
- SDCB members upset with several Mi Via services being discontinued in Centennial Care.
- Inconsistent information from call centers.
- Need more outreach to recipients.
- In some areas, service providers are hard to find (i.e., psychiatry, case management, and dentistry).
- MCOs should not charge for training for provider billing.
- Difficulty with the release of medical records.
- Confusion about eligibility.
- Forms need to be improved.
- Notices to Medicaid recipients are confusing.
- MCOs lack information about members’ guardianship.
- Members are being discharged without needed Durable Medical Equipment (DME).
- The appeals process is confusing.

- The ICSS is being implemented too slowly.

The commenters appreciated the opportunity to comment. Several positive comments related to Native American issues were expressed. The NATAC is helping to resolve issues, and the FFS option is appreciated.

There were some additional comments that did not relate directly to Centennial Care. These included:

- Concerns and confusion about the ACA and healthcare.gov.
- Concerns with lack of BH facilities in the State.
- Slow rollout of presumptive eligibility/Medicaid onsite application assistance (PE/MOSAA) at jails/detention centers.
- Request for Medicaid reimbursement for chiropractic services.
- More BH early treatment for children.

Section III: Total Annual Expenditures

Table #8. Waiver Year 1 Expenditures

Medicaid Eligibility Group (MEG)	Program Expenditures	Administrative Expenditures
MEG01 – TANF & Related	\$ 1,431,816,687	\$104,777,254
MEG02 – SSI & Related - Medicaid Only	\$ 800,421,117	
MEG03 – SSI & Related - Dual Eligible	\$ 553,255,559	
MEG04 – “217 Like” Medicaid Only	\$ 6,996,875	
MEG05 – “217 Like” Dual Eligible	\$ 86,668,978	
MEG06 – VIII Group - Medicaid Expansion	\$ 1,013,050,763	\$ 34,035,301
MEG07 – CHIP	\$ 80,630,533	\$ 925,348
MEG08 – Uncompensated Care Pool	\$68,889,322	
Grand Total	\$4,041,729,834	\$ 139,737,903

Source: New Mexico CMS 64 Submissions, FFY14 Quarter 2 through FFY15 Quarter 1

Section IV: Yearly Enrollment Report

Table #9. DY1 Enrollment

Demonstration Population	WY1 Member Months (as of 3/6/15)	WY1 Enrollment (as of 3/6/15)
Population 1 – TANF and Related	1,112,540	375,379
Population 2 – Supplemental Security Income (SSI) and Related – Medicaid Only	124,135	41,829
Population 3 – SSI and Related – Dual	106,476	39,114
Population 4 – 217-like Group – Medicaid Only	678	278
Population 5 – 217-like Group – Dual	6,579	2,732
Population 6 – VIII Group (expansion)	564,061	236,707
Totals	1,915,795	696,039

Note: This data was extracted on March 6, 2015. Due to retro-active eligibility, member months continue to increase slightly after the end of the waiver year.

Additional detail on enrollment and disenrollment in demonstration year one is included in the fourth quarter report that was submitted to CMS on March 13, 2015.

Section V: Managed Care Delivery System

Accomplishments

Delivery System Improvement Fund

HSD is evaluating the MCO results for the 2014 Delivery System Improvement Fund (DSIF) targets but is waiting on the submission of several outstanding items before finalizing review. The four target areas were:

1. Increase the use of electronic health records (EHR) and the number of contracted providers who participate in the exchange of electronic health information using the Health Information Exchange (HIE);
2. A minimum of 15 percent increase in telehealth “office” visits with specialists, including BH specialists, for members in rural and frontier areas;
3. A minimum of 5 percent increase in the number of members being served by Patient-Centered Medical Homes (PCMH); and
4. A minimum of 10 percent reduction in non-emergent use of the ER.

Preliminary results indicate that all MCOs will meet the targets for the PCMH and telemedicine components and that at least two of the MCOs will meet the ER diversion targets. HSD is awaiting additional information regarding the health information technology (HIT)/HIE component of the DSIF.

Once analysis is complete, HSD will allow the MCOs to release 25 percent of the funds withheld for each successfully met target. Total withheld funds were equal to 1.5 percent of capitation payments net of taxes and assessments.

Member Rewards

In the first waiver year, HSD successfully implemented the Centennial rewards program to promote and reward healthy behaviors. Some highlights from 2014 include:

- 39 percent rate of member participation.
- Over 40,000 active users registered in the online system.
- Nearly 20,000 reward catalog items ordered.
- Over 5,000 Centennial Rewards (debit) cards ordered.
- Over \$8 million in Centennial Rewards earned.
- Over \$600,000 in Centennial Rewards redeemed.

Administrative Burden Reduction

While not a specific component of the waiver, HSD has built requirements into its contract with the MCOs to reduce the administrative burden to providers. The hope is that health care professionals should be able to focus fewer resources on program administration and more on delivering high-quality care. In 2014, the focus of the Administrative Burden Reduction initiative

was on uniform, consistent, and simplified billing practices, credentialing processes, prior authorization, and other areas that could make program participation easier.

Successes to date include a series of training and technical assistance events for BH providers and the development of a single set of forms across all four MCOs for use in prior authorization. A workgroup is also continuing its work on standardized forms and processes for credentialing both facility-based and individual providers.

Community Health Workers

New Mexico has a long tradition of relying on trusted community members to support and educate their neighbors on health-related issues. In New Mexico, where 32 of the state's 33 counties are designated by the Health Resources and Services Administration as health professional shortage areas for primary care, community health workers (CHWs) are frontline public health workers who are trusted members of the communities they serve. This trusting relationship enables the CHW to serve as a liaison, link or intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

CHWs are being utilized in Centennial Care to address population health issues and supplement primary care, specifically by improving health and health care literacy, establishing member linkages to community supports, and supporting care coordination. The Centennial Care MCOs are required to make CHWs available to their members, and specifically report using CHWs to:

- Educate referred members about alternatives to emergency room use;
- Locate members to obtain HRAs;
- Ensure that members have the required basic life necessities to remain healthy and safe;
- Assist members with making and keeping health care appointments and arranging transportation, if needed;
- Refer members to local resources found within communities (i.e., food pantries, utility assistance and housing);
- Provide wellness support;
- Locate unreachable members for care coordination; and
- Provide translation services.

In addition, the state has partnered with the University of New Mexico (UNM) and a rural FQHC to develop a pilot program, Centennial Patient Support, in collaboration with the Centennial Care MCOs. This pilot will leverage the Centennial Care care coordination program by implementing three levels of Medicaid patient support through the deployment of CHWs. The three levels of Medicaid patient support will include:

- Community Health Improvement (Level 1) – addressing local policy, system and environmental change to improve underlying causes of ill health.
- Patient Support (Level 2) – stopping the further progression of disease and ensuring access to preventive services.
- Intensive Care Coordination (Level 3) – concentrated support for high-risk and high-cost members, in terms of specific intervention strategies that are urgent and designed to improve health and reduce costs through the development of individualized plans and 100% case review.

New Mexico will roll out the Centennial Patient Support pilot in 2015, with the goal of further evaluation and dissemination/replication to other FQHCs throughout the state in 2016.

Project Status

The demonstration project has moved from its implementation phase in demonstration year one to steady state in 2015. There are no major issues that jeopardize implementation of the waiver.

In year two of the demonstration, HSD will focus on MCO performance improvement activities including delivery system improvement targets. Other goals include:

- Continuing to refine and improve care coordination in Centennial Care;
- Launching health homes;
- Moving toward risk adjusted rates;
- Developing processes for enrolling jail involved individuals into the program;
- Implementing the State Innovation Model (SIM) design project with the Department of Health (DOH);
- Transitioning the medically-fragile population into Centennial Care; and
- Continuing to work toward optimal integration of care for dually-eligible and BH populations.

Utilization Data

Significant work was done to revise the MCO utilization report and the CSA report, in order to have a clear understanding of all integrated services during the first year of Centennial Care. Originally, the utilization report included BH services only, but was expanded to include PH and LTC services. The report includes year-to-date utilization data. Since this is the first time MCOs have reported utilization for PH and LTC in this report, HSD is working with the MCOs to validate the data to ensure accuracy. BH utilization data is reported below. Utilization data for PH and LTC will be reported in the first quarter of 2015.

BH Services

Report #41 captures key information about Centennial Care to monitor service utilization patterns. The report was patterned closely after the previous BH utilization reporting template to provide tracking of pre-and post-Centennial Care utilization. The report examines utilization of

over 200 BH services in five categories: inpatient, residential, intensive outpatient, recovery, and outpatient. It shows the unduplicated number of members receiving services by age group, as well as units of service and expenditures.

Table #10. Medicaid Managed Care Members Receiving BH Services in WY1

	Unduplicated BH Service Recipients*	Total CC 2014 Enrollment as of 1/2/2015	BH service users/All
PHP	28,874	195,191	14.79%
MHNM	36,917	209,788	17.60%
UHC	11,975	75,873	15.78%
BCBSNM	20,627	114,493	18.02%
Total	98,393	595,345	16.53%

* Based on claims data.

Table 10 above indicates that 16.5 percent of all enrolled Centennial Care members received one or more BH services during the first waiver year.

New Mexico continues to monitor utilization of BH services to ensure that the capacity for providing services to members was not reduced with the implementation of Centennial Care. For comparability, Centennial Care utilization in WY1 is compared to pre-Centennial Care utilization. Prior to Centennial Care, a single state-wide entity managed all BH services (i.e., Medicaid Managed Care, Medicaid FFS and non-Medicaid state and federal block grant funds.) This period of pre-Centennial Care utilization was chosen to reduce any potential impact to the utilization report due to the program integrity activities and pay holds implemented with 15 BH providers prior to Centennial Care (July-December 2013).

Table #11. Recipients Receiving BH Services by Age*

Age Groups	WY1				Pre-CC SFY2013** and ***
	Centennial Care Members	Medicaid FFS	Non-Medicaid	Total	
Under 18	45,353	19,794	6,757	71,904	38,837
18-20	3,944	695	1,254	5,893	4,594
21 -64	47,434	9,401	21,565	78,400	43,361
65 and over	2,532	2,413	1,211	6,156	1,807
Total**	98,393	32,306	29,883	160,582	87,373

* Based on claims data.

**Total will not equal sum of age groups as there will be some duplication.

*** Unduplicated count, all funds, 12 months July 2012-June 2013

Table 11 shows that during the first waiver year, 73,209 additional individuals received BH services. This represents an 84 percent increase in individuals receiving BH services from all funds (160,582 persons) as compared to the pre-Centennial Care SFY13 (87,373 persons).

Both Medicaid members and non-Medicaid recipients were primarily served, during this reporting period, in outpatient services (97 percent and 90 percent respectively). A higher proportion of Medicaid members (6.4 percent) received inpatient services than non-Medicaid recipients (2.7 percent). A notably higher percent of non-Medicaid recipients were served in recovery services (18.3 percent vs 9.3 percent for Medicaid members) and in residential services (7.1 percent vs. 1.6 percent).

Table #12. Unduplicated Count of Recipients Served By Service*

	WY1				Pre-CC SFY2013***
	Centennial Care members	Medicaid FFS	Non- Medicaid	Total	
Inpatient	6,280	Not available	809		5,030
Residential	1,610	Not available	2,113		3,971
Intensive Outpatient	1,760	Not available	896		2,296
Recovery	9,115	Not available	5,462		17,956
Outpatient	95,733	Not available	26,964		81,512
Value Added Services					1,264
Uncategorized					8,053
Unduplicated -All Services **	98,393	32,306	29,883	160,582	87,373

* Based on claims data.

**Totals will not equal sum of levels of care as there will be some duplication.

*** Unduplicated count, all funds, 12 months, July 2012-June 2013.

Table 12 reflects the unduplicated counts of persons served by type of service. Data on Medicaid FFS recipients, by service and related expenditures were not available at the time of this report.

Core Services Agencies (CSAs)

Report #45 is a new report under Centennial Care. The purpose of the report is to capture information on the BH services provided to members through the 16 CSAs in New Mexico. The development of this quarterly report was a collaborative effort between HSD and the MCOs.

The CSAs are multi-service agencies that help to bridge treatment gaps in the child and adult treatment systems, promote the appropriate level of service intensity for members with complex BH service needs, ensure that community support services are integrated into treatment, and develop the capacity for members to have a single point of accountability for identifying and coordinating their BH, PH, and other social services.

The CSA report was revised during 2014. In the upcoming year, the reported data will be reviewed for gaps and revisions to better clarify CSA membership and services by site and region.

Progress on Implementing Cost Containment Initiatives

HSD implemented several initiatives under the Centennial Care program during 2014 that are designed to contain costs while also improving health outcomes. While it is too early to see the results of some of these initiatives, HSD remains confident that they will ultimately be successful on both of these measures.

HSD evaluated payment reform project proposals from each of the MCOs last fall and approved at least one project for each MCO. Each are now working on an accountable care organization (ACO) or ACO-like project with provider practices around the state. HSD will continue to work with the MCOs to broaden these projects over time from pay-for-performance initiatives to more fully developed shared-risk arrangements. HSD also has commitment from the MCOs to continue exploring a bundled payment project. HSD's vision is that the results from these projects will inform the development of broader statewide payment reform initiatives in the fourth and fifth years of the waiver.

Centennial Rewards, the waiver's beneficiary engagement program, was also successfully launched during 2014 and is more fully reported on elsewhere in this report. As in payment reform, time is still needed to see if the costs for this program are more than offset by changes in beneficiary behavior that leads to lower costs and healthier members. Preliminary evaluation data is expected in early April 2015.

Finally, HSD is concluding the first year of the DSIF, also described in more detail elsewhere in this report. Reducing unnecessary visits to the ER, increasing participation in PCMHs, and increasing use of technologies like electronic medical records and telemedicine should all lead to overall lower costs and other positive outcomes.

Policy and Administrative Difficulties in Operating the Demonstration

Fiscal issues that arose during 2014 were largely driven by two factors. First, was the state's transition to its new eligibility system ASPEN. MAGI based eligibility changes as required under the ACA contributed to complicated system changes. As has been reported, various system problems occurred throughout the year that led to greater than anticipated need for capitation

reprocessing and also unanticipated movement by beneficiaries across categories of eligibility and their associated cohorts. This has manifested as swings in the Medicaid budget projections and has made it somewhat difficult to determine precise funding requirements.

The other factor was related to the transition to Centennial Care itself. With the new program came new reporting requirements and revised category of service definitions and logic. This, in turn, led to some delays in MCO reporting and some initial inaccuracies in the reports once they were submitted. These problems have largely now been resolved and HSD expects far more timely, accurate, and useful financial data during the second waiver year.

CAHPS Survey

Centennial Care MCOs are required to submit the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Results Report on an annual basis with data collected from the prior year. In the first year of the waiver, HSD worked with the MCOs to ensure the quality of the data collected through the survey and inclusion of questions that would capture data for all Centennial Care members.

HSD required the addition of child and adult care questions to elicit information from members on care coordination processes. MCOs were required to add questions to ascertain members' receipt of educational materials from the health plan related to good health, healthy behaviors and care coordination. Lastly, HSD directed the MCOs to include questions for older members in order to collect data related to the quality of falls prevention education and care.

With HSD direction, the MCOs have focused on assuring how they will manage the CAHPS survey project, provide a valid sample of applicable members, collect adequate data, review and analyze data as available and work to compile the required CAHPS report to be delivered to HSD in June of 2015.

Annual Summary of Network Adequacy by Plan

All of the MCOs serve the entire state for PH, BH and LTC. Prior to Centennial Care, three of the MCOs (BCBSNM, MHNM, and PHP) contracted with HSD for PH services. UHC contracted with HSD for LTC. OptumHealth New Mexico (OHNM), a subsidiary of UHC, contracted with HSD for BH as the state-wide entity due to its extensive BH network of providers, some of whom UHC assumed and made available to Centennial Care members.

MHNM, PHP and UHC included existing providers into Centennial Care. Therefore, some areas of the networks were well established during the readiness period. In addition to existing provider contracts being rolled into Centennial Care, PHP is unique in that it had an extensive, employed provider group as well as a contracted provider network. BCBSNM was also unique in that the MCO decided to re-contract all of its providers prior to Centennial Care.

HSD began monitoring MCO network contracting and adequacy well in advance of implementation. MCOs were required to submit a weekly ad-hoc report identifying the number of contracted providers by provider type. Sixteen provider types were tracked. The ad-hoc report was discontinued in June 2014 and replaced with a quarterly report. This report included additional provider types and specialty area providers. A comparison grid was developed for the ad-hoc report in order to closely monitor and compare progress of provider contracting and to evaluate network adequacy. For the select provider types monitored pre-implementation, MCOs made steady progress toward contracting so that by the time Centennial Care went live on January 1, 2014, the MCOs had an adequate network in place.

Table 13 below, shows several provider types' enrollment at the beginning of the contract, (December 2013) and at the close of the first demonstration year (December 2014). The table reflects increases and decreases in the network providers. For example, UHC no longer requires as many psychiatrists as it had when OHNM was the state-wide entity. Its member composition has changed. In contrast, UHC's PCS-to-member ratio is lower than the other MCOs to meet the needs of its relatively larger population of LTC members. Other adjustments were made as a result of system cleanup efforts such as: consolidation of duplicates; removal of providers who had left the service area or retired; and, removal of offices that had closed. There were identifiable concerns with the provider-to-member ratios in the first waiver year.

Table #13. December 2013 and December 2014 Provider Enrollment by MCO/plan

	BCBSNM			MHNM			PHP			UHC		
	2013	2014	2014 P-M Ratio	2013	2014	2014 P-M Ratio	2013	2014	2014 P-M Ratio	2013	2014	2014 P/M Ratio
PCP	1,098	1,794	1 : 63	1,489	1,660	1 : 126	1,290	2,030	1 : 96	1,283	2,150	1 : 35
Dental	326	578	1 : 198	564	464	1 : 452	526	669	1 : 293	207	365	1 : 209
OB-GYN	96	268	1 : 427	378	346	1 : 606	292	359	1 : 546	321	225	1 : 339
Pediatrics	101	518	1 : 221	380	682	1 : 307	270	587	1 : 334	310	326	1 : 234
Psychiatrists	247	231	1 : 495	295	232	1 : 904	219	263	1 : 745	730	66	1 : 1157
PCS	153	113	1 : 1013	137	114	1 : 1840	126	119	1 : 1648	179	148	1 : 516

Sources: [MCO] Ad-hoc reports, 2013 and [MCO] Report #3-Network Adequacy reports, 2014

Summary of Outcomes of Onsite Reviews

HSD audits of Centennial Care MCOs conducted in July 2014 revealed areas of needed improvement relating to delivery of member-centric care coordination services. As a result, an action plan was developed that provided each MCO with an opportunity to determine specific care coordination elements for focused improvements as well as conduct additional training for its care coordination staff. Applying the best practice fundamentals outlined in the action plans, each MCO provided its care coordination teams with training in October 2014 to improve documentation, identification of social support systems and resources, and coordination and monitoring of covered services.

HSD performed onsite care coordination audits in December 2014. These onsite audits were designed to assess CNAs that were developed after the October 2014 care coordination trainings. The December onsite audit revealed overall improvements to the MCOs' care coordination functions such as: engagement of members, care coordination documentation, ongoing care coordination, and care coordination processes. While improvements were identified, additional focus is needed in the areas of BH integration; family, caregiver, and provider inclusion and awareness; back-up and disaster plan development; and reassessing member needs. HSD will continue to work with the MCOs to facilitate continued improvements to care coordination processes and procedures as well as continue to monitor the MCOs' progress, conduct audits, and provide feedback.

Summary of Performance Improvement Projects

Pursuant to the Centennial Care Contract, MCO performance improvement projects (PIPs) in waiver year one focused on the following areas:

- LTC services;
- Services to children;
- PIPs as required by the CMS adult Medicaid quality grant (AMQG);
- Prevention and enhanced disease management for diabetes; and
- Screening/management for clinical depression.

HSD has contracted with HealthInsight as the External Quality Review Organization (EQRO) to assess, measure, and validate non-AMQG PIPs. The contract with the EQRO was fully executed on December 18, 2014. Once the contract was fully executed, HSD and the EQRO began developing the work plan for waiver year two.

The two PIPs managed through the CMS AMQG are:

1. Prevention and enhanced disease management for diabetes.
 - Diabetes, short-term complications admission rate.
 - Comprehensive diabetes care: low density lipoprotein-cholesterol.
 - Comprehensive diabetes care: hemoglobin A1c testing.
2. Screening/management for clinical depression.
 - Antidepressant medication management.
 - Screening for clinical depression and follow-up plan.

HSD observed an overall improvement in rates for diabetes LDL-C and HbA1c testing; diabetes short-term complications have fluctuated throughout the year among MCOs. Antidepressant medication management also continues to improve as the data becomes available and previous quarters are refreshed. The screening for clinical depression and follow-up plan continues to be a concern among all four MCOs as the providers do not use the G codes. The MCOs focus on the

proper use of G codes as they continue their outreach to providers. The MCOs report the interventions implemented to address diabetes management quarterly to HSD. The interventions include:

- Provider diabetic education toolkit with ICD-9 and CPT coding tips, documentation and lab test frequency;
- BH outreach to providers, including assessment of depression and medication management, as well as utilization of proper coding for screening and follow-up;
- Member newsletters and health fairs with education about diabetes including skin care;
- Member outreach that includes education about recognizing signs of depression and medication adherence;
- Monitoring members who were discharged from the hospital to ensure care coordination; and
- Targeted “missed services” mailings.

Outcomes of Performance Measure Monitoring

The baseline years for setting future targets and thresholds for all Centennial Care performance and tracking measures are 2014 and 2015. HSD has included eight HEDIS-based performance measures (PMs) into the Centennial Care contract that will be tracked by the EQRO. The eight PMs are as follows:

- PM #1-Annual dental visit;
- PM #2-Use of appropriate medications for people with asthma;
- PM #3-Controlling high blood pressure;
- PM #4-Comprehensive diabetes care -HbA1c testing;
- PM #5-Timeliness of prenatal and postpartum care;
- PM #6-Frequency of on-going prenatal care;
- PM #7-Antidepressant medication management; and
- PM #8-Follow-up after hospitalization for mental illness.

The PMs have a continuous enrollment requirement of greater than or equal to 365 days. The EQRO will receive the first submission of measurable MCO data in 2015 and HEDIS-like specifications will be used to evaluate the established performance measures for the first waiver year. Where HEDIS does not support using a single year of data, the EQRO has modified the specification in a HEDIS-like fashion, following HEDIS as closely as possible with the 2014 data. This process allows HSD to monitor the PMs prior to the annual audited HEDIS reports due from MCOs in July 2016.

HSD has also included three tracking measures (TMs) in the MCO contract:

- TM #1-Fall risk management;
- TM #2- Diabetes, short-term complications admission rate; and
- TM #3- Screening for clinical depression and follow-up plan.

Of the three tracking measures, two were implemented into the AMQG as quality improvement projects (QIPs). Through the QIPs, HSD has been able to work with the MCOs to identify some areas in need of improvement. Monthly conference calls have taken place over the past year to discuss the QIPs and workgroups were developed to share any issues or improvements that may be successful to others. TM #1-fall risk management is being provided to HSD from the MCOs on a quarterly basis.

Consumer Satisfaction Survey

HSD conducts an annual consumer, family/caregiver and youth satisfaction project (C/F/Y/SP) survey for Centennial Care members identified with BH needs. The C/F/YSP is a yearly survey of the satisfaction of New Mexico Adults, Family/Caregivers and Youth receiving state funded mental health and substance abuse treatment and support services. The C/F/YSP survey serves two purposes: to inform a quality improvement process to strengthen services in New Mexico; and, to fulfill federally mandated data reporting requirements. Please see Attachment G, for more information and findings from the first waiver year.

Summary of Plan Financial Performance

All MCOs submitted their fourth quarter financial reports on the due date of February 16, 2015. HSD analysis is finding fewer errors and greater compliance in these reports as the MCOs have now submitted for three quarters. However, there remain some questions and issues around how some expenditures are being categorized. HSD is also working to reconcile the data in the financial reports to MCO encounter data, as well as to those data in the programmatic reports, in order to obtain a complete analysis of services rendered and their associated costs. HSD met with all MCOs in early March to discuss broad reporting issues and will be meeting individually with each MCO to ensure the reporting of the most accurate data by the time the MCOs submit the annual financial report “update” in mid-May 2015.

The annual reporting will include a reconciliation and explanation of the prior 12-month period estimates used as part of its accrual method of accounting. This explanation will assist in understanding the MCOs’ reported financial information and will significantly increase the efficiency in determining the reasonableness of the MCOs’ allocation and expedite the completion of the MCO financial reviews. Following the annual report submission, HSD will begin the process of performing the various reconciliations that are required under the Centennial Care contract.

Analysis of Service Reductions through the Service Planning Process

HSD reviewed all service plan reduction requests for the first six months of Centennial Care. In that six month period, HSD approved two of seven requests for reduction in service plans due to members no longer meeting the requirements for the services. HSD will continue to conduct an annual review of a valid representative sample of service plan reductions for transitioning members.

Section VI: Summary of Quality of Care/Health Outcomes for AI/AN Beneficiaries

During the first year of the waiver, data indicated that all MCOs had increases for Native Americans to specialty care visits for cardiology, ENT, and orthopedic visits. All Centennial Care MCOs are striving to increase the numbers of HRAs completed in 2015 for Native Americans, some by partnering with tribal organizations to find “unable to locate” members. The MCOs are also working to increase attendance at their NAAB meetings. All MCOs have extended invitations to tribal leadership for their NAAB meetings.

In the first waiver year, three of the four MCOs saw decreased medical admissions rates for Native Americans. The average length of stay also decreased by 50 percent during 2014.

For BH services in frontier areas, all four MCOs met the access to services targets by 80 percent or more. For PH services, three of the four MCOs met access to care by 80 percent or more in frontier areas.

In WY1, frequently accessed value added services by Native American members included traditional healing, educational/incentive programs for pregnant women, dental varnish, and additional vision services. One MCO offered a value added service of sleep studies that had high utilization. Another MCO offered an upgraded transportation benefit that was frequently utilized by its Native American members.

HSD will continue to monitor health outcomes for Native American Centennial Care members through enhanced reporting from the MCOs in the second waiver year.

Section VII: Quality Strategy/HCBS Assurances

Quality Strategy

Several quality initiatives have been implemented in first year of Centennial Care, including care coordination audits performance measures tracking, critical incidents reporting and extensive MCO reporting and monitoring by HSD. Many of the quality strategy activities have been explained in other sections of this report.

Please refer to Section V for information on the care coordination audits and reviews of service plan reduction requests that took place in the first waiver year.

HSD continues to review high NF LOC and community benefit NF LOC denials on a quarterly basis to ensure the denials were appropriate and based on NF LOC criteria. No concerns were identified in 2014. Please see Section II for more information on NF LOC reviews and community benefit services reviews.

In 2014, HSD and the EQRO finalized an external audit tool to be used by the EQRO starting in waiver year two. Please refer to Section V for more information on performance measure monitoring.

Please refer to Section II for information on critical incidents monitoring.

HCBS Assurances

As previously stated, the EQRO contract was executed in December 2014 and planning for EQRO monitoring activities that include HCBS began immediately. HSD uses the CMS approved Centennial Care Quality Strategy to monitor the HCBS assurances. There are four assurance areas identified in the quality strategy.

Level of Care (LOC) Determinations

During WY1, HSD conducted audits of NF LOC determinations to ensure that members being served through the community benefit have been assessed to meet the required LOC for those services. Please refer to Section II for more information on the NF LOC reviews.

Service Plans

To ensure that MCOs appropriately create and implement service plans based on members' identified needs, HSD conducts monthly audits of each MCO to ensure the appropriate implementation of community benefit service plans. Please refer to Section II for more information on HCBS service plan audits.

MCO Credentialing and/or Verification Policies

HSD manages provider enrollment for Agency-Based Community Benefit (ABCB) service providers. All interested providers are required to submit an initial application and annual recertifications to HSD to demonstrate that all required provider qualifications are met. HSD

ensures that ABCB providers have the appropriate licensure/certification from the appropriate credentialing body. HSD does not accept incomplete applications and denies provider applications that do not meet all applicable provider enrollment requirements and qualifications. This includes services that require licensing such as assisted living, adult day health, nursing, maintenance therapies and environmental modifications. This process also includes ABCB providers who do not require licensure but do require approval by the State through the provider credentialing process.

HSD regularly sends the MCOs the current list of approved ABCB providers to ensure the MCOs only contract with providers who have been credentialed/re-credentialed by the HSD. In addition, HSD analyzes and monitors the number of providers for the entire Centennial Care program through quarterly network adequacy reports and compares the MCO provider report to the HSD list of approved providers.

SDCB providers are not credentialed directly by the MCOs, but are credentialed by the FMA on behalf of the MCOs. The MCOs contract directly with the FMA for their services that include SDCB provider credentialing and payments to providers.

Health and Welfare of Enrollees

HSD ensures that the MCOs, on an ongoing basis, identify, address, and seek to prevent instances of abuse, neglect and exploitation (ANE). HSD monitors the CI database and MCO reports, follows-up on reports of ANE, and ensures that other agencies are notified as appropriate. HSD provides updates on these activities to CMS in the quarterly reports. Please refer to Section II for the waiver year one report on adverse incidents.

Section VIII: Enclosures and Attachments

Attachment A: Budget Neutrality Spreadsheet

Attachment B: 2014 Value Added Services

Attachment C: 2015 Value Added Services

Attachment D: Contract Amendment #3

Attachment E: EVV Corrective Action Plan (CAP)

Attachment F: Critical Incidents

Attachment G: Satisfaction Survey

Section IX: State Contacts

HSD Staff Name and Title	Phone Number	Email Address	Fax
Nancy Smith-Leslie Acting Director HSD/Medical Assistance Division	(505)827-7704	Nancy.Smith-Leslie@state.nm.us	(505)827-3185
Matt Onstott Deputy Director HSD/Medical Assistance Division	(505)827-6234	Matt.Onstott@state.nm.us	(505)827-3185
Russell Toal Deputy Director HSD/Medical Assistance Division	(505)827-1344	Russell.Toal@state.nm.us	(505)827-3185
Angela Martinez Bureau Chief for Centennial Care HSD/Medical Assistance Division	(505) 827-3131	AngelaM.Martinez@state.nm.us	(505)827-6263