NEW MEXICO

MEDICAID

MANAGED CARE PROGRAM

QUALITY STRATEGY

September 2017 Update

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Section I: Introduction:

CMS requirement CFR §438.340(a)

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

Program History

CMS requirement CFR §438.340

Include a brief history of the state's Medicaid (and CHIP, if applicable) managed care programs.

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

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

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

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

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

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

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

Centennial Care

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

In 2014, New Mexico embarked on a new path to deliver integrated care to the Medicaid population through a Section 1115 Demonstration Waiver known as Centennial Care. The 1115 Demonstration Waiver consolidated all previous federal waivers, with the exception of the Medically Fragile Waiver (MFW), the Developmentally Disabled Waiver, and the Mi Via ICF/IID Waiver. Similarly, the MCO contracts were reduced from seven to four.

The Section 1115 Demonstration Waiver, Centennial Care, was approved by CMS for a 5 year period, beginning in January 2014 through December 2018. Centennial Care modernizes the Medicaid program by improving the efficiency and effectiveness of healthcare delivery; integrating physical health, behavioral health and long-term services and supports (LTSS); advancing person-centered models of care; and slowing the rate of growth in program costs. Guiding principles for Centennial Care include:

- Developing a comprehensive service delivery system;
- Increasing personal responsibility;
- Encouraging active engagement of members in their health care;

- Emphasizing payment reforms to incentivize quality versus quantity of services; and
- Maximizing opportunities to achieve administrative simplification.

Today, four MCOs administer the full array of services in an integrated model of care. The care coordination infrastructure is an integral focus of Centennial Care and promotes a person-centered approach to care with more than 900 care coordinators ensuring members receive services in the right place when they need them. Centennial Care increased access to LTSS for people who previously needed a waiver allocation to receive such services by allowing any Medicaid member who meets a NF LOC to access home and community based services (HCBS). As a result, New Mexico experienced an increase of 11.4% individuals receiving HCBS between 2014 and 2016.

Also in 2014, New Mexico became an expansion state under the Affordable Care Act. The total enrollment in the Medicaid program has grown 8.5% per year since 2014 while the per capita costs have decreased by 1.5% between 2014 and 2016. Centennial Care demonstrated improved utilization of health care services and cost-effectiveness despite significant enrollment growth.

In 2016, New Mexico launched two Health Homes sites targeting individuals with serious mental illness or severe emotional disturbance. The Medicaid program continues to see an increase in members participating in a patient centered medical home (PCMH) with over 300,000 members to date.

In November 2017, HSD/MAD will submit the Centennial Care 1115 Waiver renewal. In the renewal application, New Mexico has identified opportunities for continued progress in transforming its Medicaid program into an integrated, person-centered, value-based delivery system through the implementation of Centennial Care 2.0; therefore, building on the many successes and accomplishments achieved since implementation of the program.

Quality Management Structure

Include an overview of the quality management structure that is in place at the state level.

The Quality Bureau (QB) within HSD/MAD currently consists of 14 positions plus a bureau chief. The QB is structured with three units: Care Coordination Unit (CCU); Performance Measure Unit (PMU); and the Critical Incident Unit (CIU). The CCU conducts oversight and monitoring activities related to MCO care coordination requirements. The PMU conducts oversight of MCO quality performance and improvement initiatives and manages both the External Quality Review Organization and the 1115 Demonstration evaluation activities. The CIU conducts oversight of the reporting of critical incidents by MCOs and provider monitoring to ensure the health and welfare of members for 14 categories of eligibility (COE). All units operate in accordance within applicable state and federal regulations as well as MCO contract and policy requirements.

The QB is responsible for directing the Division's Quality Program and coordinating existing quality improvement and future health reform initiatives with contracted MCOs. The bureau

oversees all aspects of performance measurement for Centennial Care including quality improvement projects, performance measures and performance evaluation and reporting. The State retains ultimate authority and accountability for ensuring the quality initiatives of Centennial Care are accomplished, although several internal and external collaborations/partnerships are utilized to address specific initiatives and/or issues. Administrative authority for the Quality Strategy lies within the HSD/MAD Director's Office and is delegated to the QB for development, revision, evaluation, and reporting.

Section II: State Standards:

Quality and Appropriateness of Care Standards

CMS requirement CFR §438.340(b)

Summarize the procedures that assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO contracts, and to individuals with special health care needs.

Quality Management and Quality Improvement Standards:

MCOs are required to comply with state and federal standards for quality management and quality improvement (QM/QI) and shall adhere to the following:

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

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

Utilization Management Standards:

HSD/MAD requires that the MCOs establish and implement a utilization management (UM) system that follows the National Committee for Quality Assurance (NCQA) UM standards and

promotes quality of care, adherence to standards of care, and efficient use of resources, member choice, and the identification of service gaps within the service system. The MCO UM system must:

- Ensure members receive services based on their current conditions and effectiveness of previous treatment;
- Ensure services are based on the history of the problem/illness, its context and desired outcomes;
- Assist members and/or their representatives in choosing among providers and available treatments and services;
- Emphasize relapse and crisis prevention, not just crisis intervention;
- Detect over and underutilization of services to assess quality and appropriateness of care furnished to members with special health care needs; and
- Accept the uniform prior authorization form for prescriptions drug benefits and respond to prior authorization request within three (3) business days.

MCO Accreditation Standards:

The MCO shall be either (i) National Committee for Quality Assurance (NCQA) accredited in the State of New Mexico or (ii) accredited in another state where the MCO provided Medicaid services and achieved New Mexico NCQA accreditation by 1/01/16.

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

CMS requirement CFR §438.340(b)(9)
Describe the mechanisms implemented by the State to identify persons who need long-term services and supports or persons with special health care needs. (This must include the state's definition of special health care needs.)

Care Coordination Standards:

A comprehensive care coordination model fosters the goal of ensuring that Medicaid recipients receive the right care, at the right time, and in the right place. MCOs establish levels of care coordination for members based on an assessment to determine the level of support that is most appropriate to meet their needs. In the event a member's needs should change, MCOs are required to reassess the individual and, as appropriate, make the corresponding changes in their care coordination level of support.

HSD/MAD requires the MCOs to conduct a standardized health risk assessment (HRA) on each member to determine if he or she requires a comprehensive needs assessment (CNA) and/or a higher level of care coordination. The CNA identifies members requiring level 2 or level 3 care coordination and is followed by the development of a Comprehensive Care Plan (CCP), which establishes the necessary services based on needs identified in the CNA. Members assigned to

care coordination level 2 or level 3 are assigned to a care coordinator who is responsible for coordinating their total care. MCOs are required to routinely monitor claims and utilization data for all members (including members who are not assigned to care coordination levels 2 or 3) to identify changes in health status and high-risk members in need of a higher level of care coordination.

Additional components of care coordination includes:

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

Access and Network Adequacy Standards

CMS requirement CFR §438.340(b)(1)

Define the network adequacy and availability of service standards for MCOs required by §438.68 and §438.206. Include examples of evidence-based clinical practice guidelines the State requires in accordance with §438.236.

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

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

The MCO must establish a mechanism to monitor adherence with Network Adequacy Standards and shall submit a Network Adequacy Report as directed by HSD/MAD to ensure compliance with the following:

- Access Standards
    - Member caseload of any PCP should not exceed two-thousand (2,000)
    - Members have adequate access to specialty providers
- Distance Requirements for PCPs (including internal medicine, general practice, and family practice types), and pharmacies
    - Ninety percent (90%) of Urban members shall travel no farther than thirty (30) miles
    - Ninety percent (90%) of Rural members shall travel no farther than forty-five (45) miles
    - Ninety percent (90%) of Frontier members shall travel no farther than sixty (60) miles
- Distance Requirements for Behavioral Health Providers practitioners and Specialty
    - Ninety Percent (90%) of Urban members shall travel no farther than thirty (30) miles
    - Ninety Percent (90%) of Rural members shall travel no farther than sixty (60) miles, unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted as approved by the State
    - Ninety Percent (90 %) of Frontier members shall travel no farther than ninety (90) miles, unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted as approved ty the State
- Timeliness requirements
    - No more than thirty (30) Calendar Days, for routine, asymptomatic, member-initiated, outpatient appointments for primary medical care
    - No more than sixty (60) Calendar Days, for routine, asymptomatic member-initiated dental appointments.
    - No more than fourteen (14) calendar Days for routine, symptomatic member-initiated, outpatient appointments for non-urgent primary medical, behavioral health and dental care
    - Within twenty four (24) hours for Primary medical, behavioral health and dental care outpatient appointments for urgent conditions
    - Consistent with clinical urgency but no more than twenty-one (21) calendar days for specialty outpatient referral and consultation appointments, excluding behavioral health
    - Consistent with clinical urgency but no more than fourteen (14) calendar days for routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments
    - Consistent with the severity of the clinical need, walk-in rather than an appointment, for outpatient diagnostic laboratory, diagnostic imaging and other testing

- Consistent with clinical urgency, but no longer than forty-eight (48) hours for urgent outpatient diagnostic laboratory, diagnostic imaging and other testing
- No longer than forty (40) minutes for the in-person prescription fill time (ready for pickup). A prescription called in by a practitioner shall be filled within ninety (90) minutes
- Consistent with clinical needs for scheduled follow-up outpatient visits with practitioners
- Within two (2) hours for face-to-face Behavioral Health crisis services

Provider Standards:
The MCO must have the appropriate licenses in the State to do risk-based contracting through a managed care network of health care providers. The MCO is required by the state to employ a full-time staff person responsible for provider services and provider relations, including all network management issues, provider payment issues and provider education.

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

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

All health care providers rendering services to Medicaid beneficiaries must render covered services to eligible recipients in the same scope, quality, and manner as provided to the general public; comply with all federal and state civil rights laws; and not discriminate on the basis of race, color, national origin, sex, gender, age, ethnicity, religion, sexual orientation, sexual preference, health status, disability, political belief or source of payment.

Evidenced-Based Clinical Practice Guideline (CPGs) from the MCOs include examples from their QM/QI plan such as Asthma, Diabetes, ADHD (Attention Deficit Hyperactive Disorder)/ADD (Attention Deficit Disorder), Depression, and Obesity. CPGs are updated every two years and analyzed for relevant member population and practitioner/specialists and disseminated to providers. Typically, measurements (i.e. Healthcare Effectiveness Data and Information Set [HEDIS]) are established and evaluated through MCO Quality Committees, NCQA, and HSD/MAD.

CMS requirement CFR §438.340(b)(6)

Detail the State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. States must identify this demographic information for each Medicaid enrollee and provide it to the MCO at the time of enrollment.

Health Disparities

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

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

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

Transition of Care Standards:

CMS requirement CFR §438.340(b)(5)

Must include a description of the State's transition of care policy.

The State is committed to providing the necessary supports to assist Medicaid beneficiaries and requires the MCOs to establish policies and procedures that adhere to the standards defined by the State in the Managed Care Policy Manual and MCO contract.

The MCOs shall facilitate and ensure a timely and seamless transition for all Medicaid members transitioning to new services or service providers without any disruptions in services.

The MCOs must identify and facilitate coordination of care for all members during various transitions including, but not limited to:

- From an institutional facility into the community;
- For members turning twenty-one (21) years of age;
- From higher levels of care to lower levels of care. (e.g. acute inpatient, residential treatment centers social detoxification programs, treatment foster care, etc.);
- For members changing MCOs (e.g. while hospitalized, during major organ and tissue transplantation, or while receiving outpatient treatment for significant medical conditions); and
- For members with special conditions, circumstances, treatment needs or ongoing needs such as (e.g. pregnancy, chronic illness, significant behavioral health conditions, chemotherapy, dialysis or durable medical equipment).

Monitoring and Compliance Standards:

CMS requirement CFR §438.340(b)(2)

Detail the State's goals and objectives for continuous quality improvement which must be measurable and take into consideration the health status of all populations in the State served by the MCO.

New Mexico's Quality Strategy utilizes a Continuous Quality Improvement (CQI) model to achieve goals and objectives outlined for the Centennial Care program.

Centennial Care is driven by the following goals:

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

Centennial Care objectives include:

1. Develop a quality framework consistent with, and pertinent to all Medicaid programs;
2. Continue use of nationally recognized protocols, standards of care and benchmarks;
3. Continue use of a system of rewards for physicians, in collaboration with MCOs, based on clinical best practices and outcomes;
4. Develop collaborative strategies and initiatives with state agencies and other external partners;
5. Build upon prevention efforts and health maintenance/management to improve health status through targeted medical management;
6. Assure the effective medical management of at risk and vulnerable populations; and
7. Build capacity in rural, frontier and underserved areas.

HSD/MAD, through the QM/QM standards, requires the MCOs to apply the CQI model and identify opportunities for measurable improvement in the health status of the population served by the MCOs. The State conducts an annual review of each MCO's QM/QI program that includes a Work Plan and Evaluation by an integrated team from the QB, the Behavioral Health Services Division (BHSD) and the Centennial Care Contracts Bureau.

HSD/MAD monitors provider access and network adequacy in a variety of ways and through various reports submitted by the MCOs. The following outlines the various methods utilized to monitor MCO provider access and network adequacy:

- Provider Satisfaction Survey
- Member Satisfaction Survey
- Secret Shopper Survey
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) results
- External Quality Review Organization (EQRO) Reviews
- MCO Call Center Reports
- Grievance & Appeals Reports
- PCP Report
- Geo Access Report
- Network Adequacy Report
- Ad Hoc Reports
- Primary Care Physician to member ratio report

In addition, the State evaluates achievement through analysis of the quality and appropriateness of care and services delivered to members by the MCOs based on member needs and the level of contract compliance of MCOs by comprehensively monitoring MCO activities on an on-going basis. The State requires monthly, quarterly, and annual reports, including Ad Hoc reports reflective of all MCO service delivery activities. Various reports evaluate structure, process, and outcome measures.

Sanctions

CMS requirement CFR §438.340(b)(7)

Detail the appropriate use of the intermediate sanctions for MCOs.

HSD/MAD has established sanctions for the failure to meet certain contract requirements by the MCO, affiliate, parent or subcontractor, and if a party fails to comply with the contract, HSD/MAD may impose sanctions.

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

HSD/MAD may impose any or all of the non-monetary sanctions and monetary penalties to the

extent authorized by federal and state law. Non-monetary intermediate sanctions may include:

- Suspension of auto-assignment of members in a MCO;
- Suspension of enrollment in the MCO;
- Notification to members of their right to terminate enrollment with the MCO without cause;
- Disenrollment of members by HSD;
- Suspension of payment for members enrolled after the effective date of the sanction and until CMS or HSD is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur;
- Rescission of Marketing consent and suspension of the MCO's marketing efforts;
- Appointment of temporary management on any portion thereof for a MCO and the MCO shall pay for any costs associated with the imposition of temporary management; and
- Additional sanctions permitted under federal or state stature or regulations that address areas of noncompliance.

The State has established monetary penalties that may include:

- Actual damages incurred by HSD and/or members resulting from the MCO's non-performance of obligations;
- Monetary penalties in an amount equal to the costs of obtaining alternative health benefits to a member in the event of the MCO's noncompliance in providing Covered Services. The monetary penalties shall include the difference in the capitated rates that would have been paid to the MCO and the rates paid to the replacement health plan. HSD may withhold payment to the MCO for damages until such damages are paid in full;
- Civil monetary penalties;
- Monetary penalties up to five percent (5%) of the MCO's Medicaid capitation payment for each month in which the penalty is assessed;
- HSD reserves the right to assess a general monetary penalty of five hundred dollars ($500) per occurrence with any notice of deficiency; and
- Other monetary penalties for failure to perform specific responsibilities or requirements.

PROGRAM ISSUES	PENALTY
Failure to comply with Claims processing as described in Section 4.19 of the contract	2% of the monthly capitation payment per month, for each month that the HSD determines that the MCO is not in compliance with the requirements of Section 4.19 of the contract

Failure to comply with Encounter submission as described in Section 4.19 of the contract	Monetary penalties up to two percent (2%) of the MCO's Medicaid capitation payment for each quarter in which the penalty is assessed. HSD will determine the specific percentage of the capitation penalty based on the severity or frequency of the infraction.
Failure to comply with the timeframes for a Comprehensive Needs Assessment for care coordination level 2 and level 3	$1,000 per member where the MCO fails to comply with the timeframes for that member.
Failure to complete or comply with CAPs/DCAPs	.12% of the monthly capitation payment per Calendar Day for each day the CAP/DCAP is not completed or complied with as required.
Failure to obtain approval of member Materials as required by Section 4.14.1 of the contract	$5,000 per day for each Calendar Day that HSD determines the MCO has provided member Material that has not been approved by HSD. The $5,000 per day damage amounts will double every ten (10) Calendar Days.
Failure to comply with the timeframe for responding to Grievances and Appeals required in Section 4.16 of the contract	$1,000 per occurrence where the MCO fails to comply with the timeframes.
For every report that meets the definition for "Failure to Report" in accordance with Section 4.21 of the contract	$5,000 per report, per occurrence With the exception of the cure period: $1,000 per report, per Calendar Day. The $1,000 per day damage amounts will double every ten (10) Calendar days.
Failure to submit timely Summary of Evidence in accordance with Section 4.16 of the contract	$1,000 per occurrence.
Failure to have legal counsel appear in accordance with Section 4.16 of the contract	$10,000 per occurrence.
Failure to meet targets for the performance measures described in Section 4.12.8 of the contract	A monetary penalty based on 2% of the total capitation paid to the MCO for the contract/ agreement year, divided by the number of performance measures specified in the contract/agreement year.

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

Below is a total by year of HSD imposed monetary penalties:

- 2014: $3,212,744.66
- 2015: $3,271,585.54
- 2016: $0

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

(This section should describe how the state initially developed the quality strategy, subsequently reviews the quality strategy for effectiveness, and the timeline/process for revision of the quality strategy.)

Development

CMS requirement CFR §438.340(c)

(This section should describe how the state initially developed the quality strategy, subsequently reviews the quality strategy for effectiveness, and the timeline/process for revision of the quality strategy.)

CMS requirement CFR §438.340(c)(1)

Include a description of how the state made (or plans to make) the Quality Strategy available for public comment.

CMS requirement CFR §438.340(c)(1)(i)

Include a description of the formal process used to develop the quality strategy. This must include a description of how the state obtained the input from the Medical Advisory Committee, beneficiaries and other stakeholders in the development of the quality strategy.

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

Include a description of how the state obtained the input of the Native American Advisory Committee in accordance with the State's Tribal consultation policy.

HSD/MAD retains the ultimate authority, management, direction and oversight of the Quality Strategy and has organized a Quality Strategy work group within the QB that is responsible for the development, evaluation, and revision of the Quality Strategy.

The work group's focus was to develop the Quality Strategy in alignment with the goals and objectives identified by HSD/MAD to provide the right amount of care, delivered at the right time, and in the right setting to all Medicaid beneficiaries. HSD/MAD believes that by driving improvements in quality, many of the goals of Centennial Care are accomplished.

New Mexico's Quality Strategy is a coordinated, comprehensive, and pro-active approach to drive quality through targeted initiatives, comprehensive monitoring, and ongoing assessment of outcome-based performance improvement. The Quality Strategy was designed to ensure that services provided to the States Medicaid beneficiaries meet or exceed the established standards for access to care, clinical quality of care and quality of services to achieve the delivery of high-quality and high value healthcare.

The key traits of high-quality, high value healthcare include:

- Effectiveness that concentrates on the appropriateness of care (care that is indicated, given the clinical condition of the member);
- Efficient and coordinated care over time that addresses the underlying variation in resource utilization, overuse, misuse, and duplication in the system and the associated costs. The system should be safe for all members, in all processes, in all programs, at all times;
- Member-Centered to encompass respect for members' values, preferences, and expressed needs; coordination and integration of care; information, communication and involvement of family and friends;
- Timeliness to address access issues with the underlying principle that care be provided in a timely manner;
- Equality of appropriate care that is based on an individual's needs, not on personal characteristics that are unrelated to the member's condition or to the reason for seeking care, such as gender, race, geographical location, disability, or insurance status; and
- Prevention and early detection to provide treatment early in the causal chain of disease, with resulting slower disease progression and to reduce the need for long-term care.

HSD/MAD developed the Quality Strategy with input from the Medicaid Advisory Committee (MAC), a diverse and comprehensive group of stakeholders and providers, including Native American Advisory Boards (NAAB) and the Native American Technical Advisory Committee (NATAC). The MAC serves as an advisory body to the Secretary of the Human Services

Department and the Medical Assistance Division Director on policy development and program administration for the Medicaid services provided to New Mexicans. The MAC encourages participation of health professionals, consumers and consumer groups, advocates, and public health entities concerned or involved with the NM Medicaid program. Additionally, quality review committees representing the various populations meet periodically to discuss quality of care issues and performance measure outcomes with the intention of improving health outcomes and safety.

HSD/MAD solicited input and recommendations regarding content and direction of the Quality Strategy from a variety of sources including;

- Medicaid beneficiaries
- The public
- Stakeholders
- Managed Care Organizations
- EQRO
- Behavioral Health Collaborative

The Quality Strategy was published on the New Mexico Human Services Department website for approximately 5 weeks prior to finalizing the document to allow all interested parties to provide feedback and public comment. The comments and feedback provided were considered and/or incorporated into the Quality Strategy as deemed applicable to the goals and objectives established by HSD/MAD.

Evaluation

CMS requirement CFR §438.340(c)(2)

Include a timeline for assessing the effectiveness of the quality strategy (e.g., monthly, quarterly, annually).

CMS requirement CFR §438.340(c)(2)(i)

Review must include an evaluation of the effectiveness of the quality strategy conducted within the previous 3 years.

HSD/MAD will continue to utilize a CQI model to evaluate and assess the effectiveness of the Quality Strategy. HSD/MAD will review the Quality Strategy annually to ensure alignment with reported outcomes from EQR technical reporting, MCO audited HEDIS reports, CAHPS survey, 1115 waiver evaluation design plan and CMS Special Terms and Conditions (STCs), reported findings from HSD internal audits and State required MCO reports, including QM/QI programs. The outcomes will be utilized to gauge effectiveness of the Quality Strategy and to determine if any necessary changes or updates to the Quality Strategy are warranted.

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

Updates to the quality strategy must take into consideration the recommendations for improving the quality of health care service furnished by the MCO including how the State can target goals

and objectives in the quality strategy to better support improvement in the quality timeliness and access to health care services furnished to Medicaid beneficiaries. Include a timeline for modifying or updating the Quality Strategy. (If this is based on an assessment of "significant changes")

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

Submit to CMS a copy of the revised quality strategy whenever significant changes are made to the document, or whenever significant changes occur within the State's Medicaid Program.

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

The State must make the results of the review available on the Website.

HSD/MAD received approval for the Quality Strategy from CMS in May 2014. The Quality Strategy was reassessed in September 2017 and revised to address the program outcomes through calendar year 2016. New Mexico will continue to assess quality outcomes to determine the need for modifications to the Quality Strategy. Upon approval of the 1115 Demonstration Waiver renewal in 2018, HSD/MAD will revise the Quality Strategy to include additional goals, objectives, and outcome measures.

All aspects of the Quality Strategy will be assessed for effectiveness to determine areas of needed improvement. The review will include an evaluation of improvements implemented from the previous year's assessment and address any significant changes made to the Quality Strategy as a result of the assessment. The State defines significant change as changes that materially affect the actual quality of information collected or analyzed. Minor changes in timeframes, reporting dates, or format are not considered significant changes. With Centennial Care 2.0 the performance measures will focus on areas that show improved member outcome with the right care at the right time and the right place as well as the integration of physical, behavioral, and long-term services and supports. The State will submit a final draft of the Quality Strategy to (CMS) for comment and feedback.

Any updates to the Quality Strategy based on "significant changes" shall be developed, reviewed, and submitted to CMS for review and feedback and will be posted on the HSD website once approved.

Section IV: Assessment

CMS requirement CFR §438.340(b)(8)

Describe how the State will assess the performance and quality outcomes achieved by each MCO.

Quality Metrics

CMS requirement CFR §438.340(b)(3)

The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO with which the State contracts, including but not limited to, the performance measures reported. The State must identify which quality measures and performance outcomes the State will publish at least annually on the Web site required. The performance improvement projects to be implemented. Include a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO

HSD/MAD defined specific Performance Measures (PMs) and targets, Performance Improvement Projects (PIPs), quality metrics for Tracking Measures (TMs), and performance targets to ensure access, quality, or timeliness of care for all Medicaid beneficiaries. The QB monitors, analyzes, trends and provides feedback and technical assistance to the MCOs to improve access, quality, and timeliness of care to all Medicaid beneficiaries.

HSD/MAD's QB and the contracted MCOs have formed a Quality Workgroup which meets quarterly to discuss quality outcomes and performance. The group was established to promote a collaboration of those responsible for ensuring quality of care and improved outcomes. The Workgroup provides an arena for discussion on gaps in care, interventions, barriers, and best practices. QB is also able to provide feedback on performance, direction and technical assistance in a group setting which encourages the collaborative effort. The group focuses on the key quality metrics defined by the State to assess performance and encourage positive outcomes.

HSD/MAD selects PMs and PIPS utilizing data that identifies the strengths and opportunities for improvement specific to the Medicaid population. PMs, PIPs and performance targets are reasonable and based on industry standards and consistent with CMS EQR Protocols. An annual review of PMs and PIPs is conducted by the EQRO and the final technical report with findings and recommendations are posted on the HSD website.

Performance Measures (PMs)

PMs and performance targets are based on HEDIS technical specification for the current reporting year. The MCO is required to follow relevant and current NCQA HEDIS standards for reporting. HSD/MAD requires the MCOs to meet the established performance targets. HSD/MAD considered calendar year 2014 and calendar year 2015 to be noncompetitive baseline years for PM thresholds and for setting PM targets.

The performance targets listed in the MCO contracts requires: 1) a two (2) percentage point improvement above the MCO's NCQA audited HEDIS rates; or 2) achievement of the Health and Human Services (HHS) Regional Average as determined by NCQA Quality Compass, or the State's determined target.

Failure to meet the established performance targets will result in monetary penalties as detailed in the MCO Medicaid contract.

HSD/MAD directed the MCOs to focus on eight (8) clinical initiatives to drive improved quality outcomes. The table below reflects the aggregate percentage by calendar year of the annual HEDIS results reported to HSD by the four (4) contracted MCOs.

Performance Measures	**2014**	**2015**	**2016**
PM#1 Annual Dental Visits	57.50%	61.50%	63.75%

PM#2 **Use of Appropriate Medication for People with Asthma**	51.75%	55.75%	56%
PM#3 **Controlling High Blood Pressure**	52.75%	53.5%	54.5%
PM#4 **Comprehensive Diabetes Care**			
HbA1C testing	85%	84.25%	83.5%
HbA1C >9%	47.5%	50%	47.5%
Retinal Eye Exam	56%	53%	56%
Nephropathy Screening	80.75%	87.5%	88.75%
PM#5 **Prenatal/Postpartum Visits**			
Prenatal visits within first trimester or within 42 days of enrollment	73%	70.5%	76.5%
Postpartum visit on or before 21 & 56 days after delivery	55%	50.75%	57.75%
PM#6 **Frequency of on-going prenatal care**	52%	44.75%	55.75%
PM#7 **Antidepressant Medication Management**			
Acute Phase 84 days	52%	53.75%	50.75%
Continuous Phase 180 days	43.5%	38.25%	35.5%
PM#8 **Follow up after hospitalization for Mental illness**			
7 days	65.75%	62%	64.75%
30 days	44.74%	39.25%	42.75%

Performance Improvement Projects (PIPs)

HSD/MAD directed the MCOs to implement PIPs designed to meet the unique needs of its members. The PIPs were developed to ensure sustainable improvements and interventions with a focus on quality improvement. The 2014 Centennial Care Managed Care Contract directed the MCOs to implement PIPs in the following areas: one (1) on Long-Term Care Services, one (1) on services to children, one (1) on Behavioral Health, and one (1) on women's health.

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

The MCO contract continues to direct the MCOs to, at a minimum, implement the following PIPs:

- One (1) on Long-Term Care
- One (1) on Services to Children
- One (1) on Diabetes Prevention and Management
- One (1) on Screening and Management for Clinical Depression

Tracking Measures

HSD/MAD directed the MCOs to report on tracking measures (TMs) that focus on a specific target populations. TMs are areas for the MCOs to evaluate and make improvements, if necessary. The MCOs are required to submit quarterly reports to HSD/MAD using the QB developed reporting template which applies HEDIS, CMS Adult Core Set, or HSD defined technical specifications. The report is analyzed by the QB to identify performance trends, best practices, gaps and interventions reported by the MCOs.

Currently, these measures do not have associated sanctions. Feedback is shared and discussed with the MCOs during the quarterly quality workgroup meetings. Below is a timeline, description and measure of the TMs implemented:

Date of Direction	Tracking Measure	Description of Target Population or Topic	2014	2015	2016
March 2014	Fall Risk Management	The Percentage of Medicaid members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 Months and who received fall risk intervention from their current practitioner.	12%	8%	12%
August 2015	Diabetes, Short-Term Complications Admission Rate	The number of inpatient discharges with a principal diagnosis code for diabetes short-term complications for Medicaid enrollees.			
		18 to 64 years of age	22%	17%	19%
		65 + years of age	88%	95%	60%

August 2015	Screening for Clinical Depression and Follow-Up Plan	The percentage of Medicaid enrollees screened for clinical depression using a standardized depression screening tool and if positive a follow-up plan is documented on the date of the positive screen.	NR		
		18 to 64 years of age	0.02%	0.07%	0.12%
		65+ years of age	0.04%	0.24%	0.26%
May 2016	Well-Child Visits in the First 15 Months of Life	The percentage of members who turned 15 months old during the measurement year and who had 6 or more well-child visits with a PCP during their first 15 months of life	NR	NR	58%
May 2016	Children and Adolescents' Access to Primary Care Practitioners (PCP)	The percentage of members 12 months – 19 years of age who had a visit with a PCP.	NR	NR	61%
October 2016	Long Acting Reversible Contraceptive (LARC)	The use of LARC among members age 15 -19 years of age.	NR	NR	3106
October 2016	Smoking Cessation	The monitoring of smoking cessations products: Cost utilization	NR	NR	$1,146,190
		The monitoring of counseling: Products and Services (Total Units) utilization			7609

Child and Adult Core Set Quality Measures

HSD/MAD reports on CMS determined Child Core Set and Adult Core Set Quality Measures through the Medicaid and CHIP Program (MACPro) systems data entry portal. The CMS defined Core Set of Quality Measures provides New Mexico with a nationally recognized set of core quality measures to track performance and identify areas needing improvement. Reporting on these performance measures will assist HSD/MAD to further enhance the quality of health care for both Children and Adults within the States Medicaid program.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

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

CAHPS Supplemental Questions *CCC-Children with Chronic Conditions *N/A- Not Reported	Year	BCBS		MHC		PHP		UHC	
Child Care Coordination									
1. In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these doctors or other health providers? (% answering Yes)	2015	27%	43% CCC	64%	71% CCC	52%	60% CCC	N/A	
	2016	28%	28% CCC	27%	44% CCC	14%	29% CCC	56%	51% CCC
2. In the last 6 months, who helped to coordinate your child's care?									
Someone from your child's health plan	2015	4%	8% CCC	13%	14% CCC	4%	9% CCC	N/A	
	2016	6%	6% CCC	5%	6% CCC	13%	20% CCC	5%	10% CCC
Someone from your child's doctor's office or clinic	2015	19%	22% CCC	55%	48% CCC	48%	50% CCC	N/A	
	2016	22%	22% CCC	24%	31% CCC	63%	57% CCC	29%	35% CCC
Someone from another organization	2015	1%	4% CCC	6%	10% CCC	6%	7% CCC	N/A	
	2016	3%	3% CCC	2%	4% CCC	0%	6% CCC	2%	6% CCC
A friend or family member	2015	5%	6% CCC	1%	1% CCC	3%	3% CCC	N/A	
	2016	4%	4% CCC	5%	3% CCC	9%	3% CCC	6%	3% CCC
You	2015	71%	60% CCC	25%	27% CCC	39%	31% CCC	N/A	
	2016	65%	65% CCC	64%	56% CCC	16%	14% CCC	59%	46% CCC
3. How satisfied are you with the help you received to coordinate your child's care in the last 6 months?									
Satisfied or Very Satisfied	2015	81%	74% CCC	86%	87% CCC	91%	88% CCC	N/A	
	2016	77%	77% CCC	90%	86% CCC	86%	87% CCC	84%	77% CCC
Adult Care Coordination									
4. In the last 6 months, did anyone from your health plan, doctor's office, or clinic help coordinate your care among these doctors or other health providers? (% answering Yes)	2015	33%		24%		27%		N/A	
	2016	38%		30%		29%		37%	
5. In the last 6 months, who helped to coordinate your care?									
Someone from your health plan	2015	9%		19%		17%		N/A	
	2016	14%		12%		34%		12%	
Someone from your doctor's office or clinic	2015	25%		48%		47%		N/A	
	2016	26%		23%		48%		21%	
Someone from another organization	2015	2%		3%		4%		N/A	
	2016	4%		1%		1%		5%	
A friend or family member	2015	14%		16%		13%		N/A	

	2016	14%	11%	8%	23%
You	2015	50%	16%	19%	N/A
	2016	43%	53%	9%	39%
6. How satisfied are you with the help you received to coordinate your care in the last 6 months?					
Satisfied or Very Satisfied	2015	80%	87%	88%	N/A
	2016	74%	81%	94%	79%
Member Education					
7. In the last 6 months, have you received any material from your health plan about good health and how to stay healthy? (% answering Yes)	2015	58%	59%	62%	N/A
	2016	73%	57%	63%	67%
8. In the last 6 months, have you received any material from your health plan about care coordination and how to contact the care coordination unit? (% answering Yes)	2015	50%	48%	50%	N/A
	2016	60%	54%	51%	59%
Care Plan					
9. Did your care coordinator sit down with you and create a plan of care? (% answering Yes)	2015	24%	24%	64%	N/A
	2016	28%	25%	54%	35%
10. Are you satisfied that your care plan talks about the help you need to stay healthy and remain in your home?					
Satisfied or Very Satisfied	2015	70%	71%	N/A	N/A
	2016	70%	83%	84%	71%
Fall Risk					
11. A fall is when your body goes to the ground without being pushed. In the last 6 months, did you talk with your doctor or other health provider about falling or problems with balance or walking? (% answering Yes)	2015	22% (12 mo.)	18%	22%	N/A
	2016	23% (12 mo.)	17%	57%	29%
12. Did you Fall in the past 6 months? (% answering Yes)	2015	19%	18%	17%	N/A
	2016	21%	15%	52%	25%
13. In the past 6 months, have you had a problem with balance or walking? (% answering Yes)	2015	27%	24%	25%	N/A
	2016	26%	20%	21%	40%
14. Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? (% answering Yes)	2015	23%	23%	26%	N/A
	2016	26%	21%	58%	38%

External Quality Review

CMS requirement CFR §438.340(b)(4)

Detail the arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each MCO.

HSD/MAD, in accordance with 42 CFR 438.354, has retained the services of an External Quality Review Organization (EQRO), HealthInsight New Mexico, to provide External Quality Review (EQR). The EQRO will conduct all mandatory and optional EQR reviews to assess quality

outcomes and timeliness of, and access to, the services provided to Medicaid beneficiaries and covered under each MCO.

The EQRO will follow CMS protocols that set forth the parameters that must be followed in conducting the EQR for the following activities:

- Compliance Monitoring, an annual review designed to determine the MCO compliance with State and Federal Medicaid regulations and applicable elements of the contract between the MCO and State. As an extension of Compliance Monitoring, the EQRO has conducted numerous educational sessions for the MCOs regarding Transition of Care 2015 and 2016 requirements;
- Validation of PMs, an annual review designed to evaluate the accuracy of the State defined performance measures reported by the MCOs;
- Validation of PIPs, an annual review designed to verify the projects developed by the MCO were designed, conducted and reported in a methodically sound manner and address the target population defined by the State;
- Validation of Encounter Data, a review conducted every three (3) years as an independent validation to measure the consistency between submitted encounter data and corresponding health record entries;
- Independent Assessment, a review conducted every three (3) years to assess the State's activities and efforts to monitor the MCOs' access to services, quality of services and cost effectiveness; and
- Audit of the MCO NFLOC determinations every quarter. HSD monitors the EQRO audit of MCO NFLOC determinations and addresses trends identified.

The MCOs are required to cooperate fully with the EQRO and demonstrate compliance with New Mexico's managed care regulations and quality standards as set forth in federal regulation and State policy.

The EQRO reports findings and recommendations to the State.

CMS requirement CFR §438.340(b)(10)

Describe how the state will ensure non-duplication of EQR **activities.**

To ensure non-duplication of EQR activities, HSD/MAD has a designated Contract Administrator authorized to represent HSD/MAD in all matters related to EQR. The Contract Administrator utilizes tracking sheets to monitor scope of work activities with relevant contractors within the division.

HSD conducts internal quality review activities such as:

- NF LOC audits by the HSD/MAD Nurse Auditor for review of service plan reduction determinations by the MCOs;

- NF LOC audits by the HSD/MAD Nurse Auditor for review of high NF LOC and low NF LOC denials on a quarterly basis to ensure the denials are appropriate and based on NF LOC criteria;
- Service Plan audits by the HSD/MAD Nurse Contractor to review service plans ensuring that the MCOs are using the correct tools and processes to create service plans. The review of service plans also ensures the MCOs are appropriately allocating time and implementing the services identified in the member's comprehensive needs assessment, and the member's goals are identified in the care plan;
- Care coordination audits evaluating and monitoring MCO care coordination activities. HSD/MAD monitors monthly progress reports from the MCOs outlining the MCOs' efforts to improve care coordination practices according to HSD/MAD's findings that required follow-up to recommendations and action steps;
- "Ride-alongs" by HSD/MAD staff were conducted with MCO care coordinators in 2015, 2016 and 2017 to observe member visits in the home setting. HSD/MAD ride-along experiences with the MCOs identified the need to continue care coordination trainings for member assessments and available services. Modifications to assessment tools and technical assistance were provided to the MCOs based on the observations. MCOs acknowledged the need for continued training and that the process was helpful to the MCO care coordinators. The ride-alongs focus on application by care coordinators of the Community Benefit Services Questionnaire (CBSQ), a tool developed collaboratively by HSD/MAD and the MCOs to educate members about available home and community based services. HSD/MAD observes the care coordinator's use of the Community Benefit Member Agreement (CBMA), to document if the member agrees to accept or decline available services;
- Monitoring MCO continued expansion of the PCMH model by engaging PCMH providers to conduct care coordination activities for their attributed members through value based purchasing (VBP) arrangements. Centennial Care 2.0 seeks to expand of this initiative by continuing to transition care coordination functions from the MCOs to the provider level (known as a delegated model). Monitoring activities shall occur through MCO reporting to HSD and verification of VBP initiatives.
- Delivery System Improvement Performance Targets (DSIPTs) allow MCOs to be recognized for their quality improvements in specific areas. In 2014 and 2015, HSD required four target areas for DSIPTs. In 2016, HSD expanded target areas by adding emphasis on five specific areas. Below is a description of DSIPTs target areas by year:

Delivery System Improvement Targets		
2014	**2015**	**2016**
HIE/HIT Increase the use of electronic health records by Contract Providers and increase the number of Contract Providers who participate in the exchange of electronic health information.	**Community Health Workers** Increase use of CHWs for care coordination activities, health education, health literacy, translation and community support linkages in Rural, Frontier, and underserved communities in Urban regions of the State.	**Community Health Workers** Increase use of CHWs for care coordination activities, health education, health literacy, translation and community support linkages in Rural, Frontier, and underserved communities in Urban regions of the State.
Telehealth A minimum of a 15% increase in telehealth "office" visits with specialists, including BH providers, for members in Rural and Frontier areas. At least 5% of the increase must be visits with BH providers**.**	**Telehealth** A minimum of a 15% increase in telehealth "office" visits with specialists, including BH providers, for members in Rural and Frontier areas. At least 5% of the increase must be visits with BH providers**.**	**Telemedicine** A minimum of a 15% increase in telemedicine "office" visits with specialists, including BH providers, for members in Rural and Frontier areas. At least 5% of the increase must be visits with BH providers**.**
PCMH A minimum of a 5% of members served by PCMHs.	**PCMH** A minimum of a 5% increase in members served by PCMHs.	**PCMH** A minimum of a 5% increase of members being served by PCMHs, maintaining a minimum of 40% of membership being served by PCHMs.
ER Diversion A minimum of a 10% reduction of non-emergent use of the ER.	**ER Diversion** A minimum of a 10% reduction in the per capita use of emergency room.	**Behavioral Health** Percent of 7-day follow-up visits into community-based BH care for child and adult members released from inpatient psychiatric hospitalizations stays of 4 or more days.
		Hepatitis C Treat at least 50% of Hepatitis C drug treatments included in the capitated rate during the contract period.

Centennial Care Summary

Accomplishments for Centennial Care, now in its fourth year of operation, include the following:

- Streamlined program administration by consolidating a myriad of federal waivers that segregate the care of populations. Four MCOs administer the full array of services in an integrated model of care, serving approximately 700,000 Medicaid members;
- Built a care coordination infrastructure that promotes a person-centered approach to care. More than 900 care coordinators ensure members receive services when they need them;
- Increased access to long-term services and supports (LTSS) for people who previously needed a waiver allocation to receive such services. More than 29,750 individuals are

receiving home- and community-based services (HCBS) which represents an increase of 11.4% per year between 2014 and 2016;

- Continue to be a leader in the nation in spending more of its LTSS dollars to maintain the number of members receiving services in their homes and in community settings rather than in institutional settings;
- Advanced payment reforms in partnership with the MCOs and, in 2017, requiring VBP arrangements for at least 16% of all medical payments to providers; and
- Demonstrated improved utilization of health care services and cost-effectiveness of the program despite significant enrollment growth. Total enrollment in the Medicaid program has grown 8.5% per year since 2014 while per capita costs have decreased by 1.5% between 2014 and 2016.