Centennial Care Waiver Demonstration

Section 1115 Annual Report
Demonstration Year: 4 (1/1/2017 – 12/31/2017)

April 6, 2018

New Mexico Human Services Department

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SECTION I: INTRODUCTION

On July 12, 2013, the Centers for Medicare and Medicaid Services (CMS) approved New Mexico's Centennial Care Program 1115 Research and Demonstration Waiver. The approval of the waiver is effective from January 1, 2014 through December 31, 2018.

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. Approximately 670,000 members are currently enrolled in the program.

The goals of the Centennial Care Program at implementation included:

- Assuring that Medicaid recipients in the program receive the right amount of care at the right time and in the most effective settings;
- Ensuring that the care being purchased by the program is measured in terms of its quality and not its quantity;
- Slowing the growth rate of costs or "bending the cost curve" over time without cutting services, changing eligibility or reducing provider rates; and
- Streamlining and modernizing the program.

In the development of a modernized Medicaid program, New Mexico articulated four (4) guiding principles:

1. Developing a comprehensive service delivery system that provides a full array of benefits and services offered through the State's Medicaid program;
2. Encouraging more personal responsibility so that recipients become more active participants in their own health and more efficient users of the health care system;
3. Increasing the emphasis on payment reforms that pay for performance rather than payment for the quantity of services delivered; and
4. Simplifying administration of the program for the State, for providers and for recipients where possible.

These guiding principles continue to steer New Mexico's Medicaid modernization efforts and serve as the foundation for the 1115 demonstration waiver.

The four Managed Care Organizations (MCOs) contracted with New Mexico to deliver care are:

- Blue Cross Blue Shield of New Mexico (BCBS)
- Molina Healthcare of New Mexico (MHC)
- Presbyterian Health Plan (PHP)
- UnitedHealthcare (UHC)

SECTION II: SUMMARY OF QUARTERLY REPORT OPERATIONAL ISSUES

Annual Budget Neutrality Monitoring Spreadsheet

The annual budget neutrality monitoring spreadsheet for demonstration year four (DY4) is included in this report as Attachment A.

Health Care Delivery System Update

Benefits

There were no changes in Medicaid Covered Services during DY4; however, MCOs began offering In Lieu of Services or Settings, which are alternative services or settings that are not Covered Services, but are medically appropriate and cost effective substitutes. Approval from the Human Services Department (HSD) is required prior to utilization. In addition, the MCOs offer Value Added Services (VAS) to their members, which are approved by HSD to supplement Covered Services. VAS vary by MCO and are outlined in Attachment B: 2017 Value Added Services.

New Mexico Consumer, Family/Caregiver and Youth Satisfaction Project

The New Mexico Consumer, Family/Caregiver and Youth Satisfaction Project (CFYP) is a yearly effort to survey the satisfaction of New Mexico Adult individuals, Family/Caregivers and Youth receiving state funded mental health and substance abuse treatment and support services.

The CFYP surveys serve two purposes:

- To inform a quality improvement process to strengthen services in New Mexico; and,
- To fulfill federally mandated data reporting requirements.

Adults, family members and youth answer the survey through face-to-face or telephone interviews. Provider locations for face-to-face interviews are pre-selected each year. Telephone interviews were obtained from a pool of randomly-selected individuals or families who received behavioral health services from New Mexico Medicaid or Behavioral Health programs between July 2016 and February 2017. There is a separate Youth Report which surveys youth in detention centers and shelters; NM Children Youth & Families Department (CYFD) will make results available in late fall, 2017. For more information and findings from DY4, please see Attachment C: 2017 NM Consumer and Family Executive Summary.

Enrollment

Centennial Care enrollment indicates the largest increase in enrollment continues to be Group VIII. The majority of Centennial Care members are enrolled in TANF and Related with Group VIII being the next largest group as reflected in Section IV of this report. There were some decreases in Group VIII, SSI and Related, both Medicaid Only and Dual but the other groups

increased other than 217-Like-Medicaid Only which remained stable. Overall, enrollment has started to decrease each quarter in almost every population other than the 217-Like populations, primarily related to failure of members to recertify at time of recertification.

Disenrollment

HSD continues to monitor disenrollment and any potential issues. Validation checks are run periodically to identify any possible concerns. Any issues that are identified or reported are researched and addressed.

Complaints and Grievances

In DY4 a total of 4,081 member grievances were filed by Centennial Care members; an increase from DY3 (3,787), a decrease from DY2 (4,385), and an increase from DY1 (2,668). There were 871 member grievances received in Q4, 1,184 received in Q3, 1,058 received in Q2 and 968 received in Q1.

In DY4 the top member grievance filed was Non-Emergency Ground Transportation (NMET) with 1,519 (37.22%) of the total grievances received; an increase from 919 received in DY3, 1,241 received in DY2, and 1,006 received in DY1. The MCOs continue to meet regularly with their transportation vendors to ensure members' concerns are addressed and any barriers to care are removed. Process improvement initiatives have been made such as reviewing daily and monthly reports to track and address recurring member issues, hiring of additional resources, providing direction to their vendors and implementing performance plans.

In DY4 the second top member grievance filed was related to Other Specialties with 301 (7.38%) received; a decrease from 514 received in DY3, equal to 301 received in DY2, and an increase from 134 received in DY1. Balance billing, the practice of billing the member for a remaining balance, was the primary issue. Providers are unable to balance bill Medicaid recipients and so the MCOs follow up on all of these instances to resolve the issue. Additionally, the MCOs continue to provide outreach to the top providers identified so that they understand the policy.

The third top member grievance filed was related to Primary Care Physician (PCP) with 118 (2.89%) received; a decrease from 410 received in DY3, 428 received in DY2, and 198 received in DY1. Reported grievances include complaints about appointment timeliness, quality of service issues and dissatisfaction with the PCP for not authorizing requested prescriptions. The MCOs communicate regularly with all departments involved in member grievances to ensure members' concerns are addressed and any barriers to care are removed.

In DY4 the remaining 2,143 (52.51%) grievances are noted, but the information found does not establish a trend. These grievances include complaints about dental, pharmacy and emergency room services. The MCOs state that they are closely analyzing the data to identify needed changes to their internal processes and to assess any gaps or issues to decrease the overall number of grievances.

Table 1 – MCO Grievances DY4

MCO Grievances DY4										
MCO	**BCBS**		**MHC**		**PHP**		**UHC**		**Total**	
Member Grievances	#	%	#	%	#	%	#	%	#	%
Number of Member Grievances	723	17.72%	1,359	33.30%	817	20.02%	1,182	28.96%	**4,081**	100.00%
Top Member Grievances										
Transportation Ground Non-Emergency	387	9.48%	401	9.83%	244	5.98%	487	11.93%	**1,519**	37.22%
Other Specialties	12	0.29%	0	0.00%	63	1.54%	226	5.54%	**301**	7.38%
Primary Care Physician	4	0.10%	32	0.78%	82	2.01%	0	0.00%	**118**	2.89%
Variable Grievances	320	7.84%	926	22.69%	428	10.49%	469	11.49%	**2,143**	52.51%

Member Appeals

In DY4 a total of 3,932 member appeals were filed by Centennial Care members. This was a decrease from DY3 (5,104) and DY2 (5,435) and an increase from DY1 (1,764). Of those 3,932 member appeals, 3,592 (91.35%) were standard member appeals and 340 (8.65%) were expedited member appeals. During 2017 a total of 1,013 member appeals were received in Q4, 1,000 received in Q3, 1,043 received in Q2 and 876 received in Q1. All MCOs processed acknowledgement notices in a timely manner.

Denial or limited authorization of a requested service constitutes the largest number of appeals reported with 3,296 (83.83%). Member appeals included criteria for services not met, including denial of inpatient stay, pharmacy, and dental services. MCO interventions included member education and referrals to the MCO Medical and Clinical Operations Directors for continued ways to improve processes.

The second top reason for appeals was the reduction of a previously authorized service with a total of 332 (8.44%) member appeals. These member appeals included dissatisfaction with reduction in personal care service hours (PCS) or home health services and denied requests for long term care services due to not meeting the nursing facility level of care criteria (NF LOC). HSD continues to monitor reductions in PCS hours as well as NF LOC determinations through auditing. The audits show the majority of the reductions in PCS hours were due to increased natural support or independence with ADL's and NF LOC denials are consistent with NF LOC criteria.

There were 304 (7.73%) variable appeals in DY4. Of those, each MCO reported unique appeals during each quarter that do not establish a trend. All MCOs have complied with the policies and procedures regarding members' exhaustion of the Grievance and Appeal System prior to requesting a State Fair Hearing.

Table 2 – MCO Appeals DY4

MCO Appeals DY4										
MCO	**BCBS**		**MHC**		**PHP**		**UHC**		**Total**	
Member Appeals	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	%
Number of Standard Member Appeals	351	8.93%	650	16.53%	2,043	51.96%	548	13.94%	**3,592**	91.35%
Number of Expedited Member Appeals	75	1.91%	86	2.19%	25	0.64%	154	3.92%	**340**	8.65%
Total	426	10.83%	736	18.72%	2,068	52.59%	702	17.85%	**3,932**	100%
Top Member Appeals										
Denial or limited authorization of a requested service	317	8.06%	702	17.85%	1,773	45.09%	504	12.82%	**3,296**	83.83%
Reduction of a previously authorized service	7	0.18%	21	0.53%	200	5.09%	104	2.64%	**332**	8.44%
Variable Appeals	102	2.59%	13	0.33%	95	2.42%	94	2.39%	**304**	7.73%
Empty Variables									**0**	0.00%

Access

Throughout this report, unless otherwise noted, the most current monthly data available is through February 2018. Quarterly data is available through the third quarter of 2017.

To ensure the MCOs' compliance in maintaining member access and an adequate provider network, HSD monitors new and terminated providers, member-to-provider ratios and GeoAccess reports. All MCOs were far below the primary care provider (PCP)-to-member contractual required ratio of 1:2000 in DY4. The ratios ranged from 1:27 to 1:102 as reported by the MCOs in the third quarter. Please see Table 3: PCP-to-Member Ratios by MCO.

Table 3 – PCP-to Member Ratios by MCO

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep
BCBS	1:39	1:39	1:40	1:38	1:38	1:38	1:35	1:35	1:36
MHC	1:102	1:102	1:102	1:100	1:99	1:99	1:98	1:96	1:94
PHP	1:88	1:88	1:86	1:87	1:86	1:84	1:83	1:81	1:82
UHC	1:30	1:30	1:30	1:29	1:29	1:29	1:28	1:28	1:27

Source: [MCO] PCP Report #53, Q3CY17

Geographic access requirements for dentists, hospitals, pharmacies, primary care physicians, and most specialty providers were met in urban, rural and frontier counties. A shortage of providers continues in specialty areas including dermatology, endocrinology, neurology, neurosurgeons, rheumatology, and urology. New Mexico recognizes providers/pharmacies within 100 miles of the border as in-state providers. In areas that MCOs do not meet access criteria, they utilize non-emergency transportation, telemedicine, and single case agreements to ensure that the members who require medically necessary services receive them. Please see Attachment D: 2016-17 GeoAccess PH Summary All MCOs.

In DY4, MHC terminated its contract with Walgreens Pharmacy; however, member access standards were not affected. Members were notified of nearby pharmacy providers and for those members in care coordination levels 2 and 3, care coordinators provided individualized assistance with the transition. Additionally, the DaVita Medical Group notified MHC that it would terminate its contract with MHC and no longer serve MHC members effective December 1, 2017. This termination did not impact member access standards; members were either transitioned within the MHC provider network or allowed to switch to another MCO to ensure continuity of care with DaVita.

Behavioral Health Geo Access

Access standards continued to be met, statewide, for behavioral health (BH) services with few exceptions and little change in urban, rural and frontier areas through Core Service Agencies (CSA), Community Mental Health Centers (CMHC), Outpatient provider agencies, psychiatrists, psychologists, Suboxone certified MDs, and other licensed independent behavioral health practitioners. With a few exceptions, none of the urban, rural and frontier access standards were met for residential treatment programs, both accredited and non-accredited, Indian Health Services and Tribal 638s providing BH, Day Treatment Services, and Rural Health Clinics providing BH services

In rural and frontier areas, access standards remained unmet with limited exceptions, for the following: Freestanding Psychiatric Hospitals; General Hospitals with psychiatric units; partial hospital programs; Treatment Foster Care 1 & 2; Behavioral Management Services; Day Treatment Services; Intensive Outpatient Services; Methadone Clinics; Assertive Community Treatment (ACT); and Multi-Systemic Therapy (MST). Rural access standards for Federally Qualified Health Centers (FQHCs) are not met by the majority of MCOs.

HSD continues to be aware of the BH services that do not meet the standards due to a limited number of providers in New Mexico. HSD continues to work with the MCOs to strengthen their relationships with providers and to increase accessibility to those in areas not meeting access through increased opportunities to utilize telemedicine, including psychiatry consults through the University of New Mexico, and Project ECHO.

MCOs have worked throughout the year to maintain access within the current network while striving to build accessibility through efforts to provide innovative service delivery to their members and by utilizing care coordinators, family and peer supports and Community Health Workers (CHWs). MCOs support their available networks in ways such as having Behavioral Health Provider Service Representatives routinely vist providers to validate practice information, respond to claims issues and answer provider questions. Please see Attachment E: 2017 BH GeoAccess Summary All MCOs.

Secret Shopper Survey

Medicaid-enrolled providers with the State of New Mexico are potentially able to contract with

any of the four Centennial Care MCOs, all of which provide services to members statewide. Beginning in DY4, MCOs are required to conduct Secret Shopper Surveys with Primary Care Providers (PCPs) semi-annually to monitor appointment timeliness in all regions across the State for routine and urgent visits. MCOs create their own survey scripts that are approved by HSD.

Telemedicine

All MCOs continued to utilize telemedicine services for both PH and BH. In DY4 the majority of telemedicine visits were for BH services. All MCOs continue to promote use of technology to allow members to have access to telemedicine services and are working with large in-state providers of telemedicine specialty services to make sure rural and frontier PCPs are aware of their availability. Technical assistance was offered to providers who are interested in delivering services via telemedicine. Primary interventions include provider education regarding accurate coding of telemedicine services. Additionally, the MCOs continue to inform members of the availability of telemedicine as they strive to meet the goal of an increase in member utilization by 15% over DY3. Please see Table 4: Telemedicine 2013 - 2017 Results.

Table 4 – Telemedicine 2013 - 2017 Results

Telemedicine Professional Services
(Number of visits for Rural and Frontier Members)

	Baseline			1st Year Results			2nd Year Results			3rd Year Results			4th Year Results		
	2013 Behavioral Health	2013 Physical Health	2013 Total	2014 Behavioral Health	2014 Physical Health	2014 Total	2015 Behavioral Health	2015 Physical Health	2015 Total	2016 Behavioral Health	2016 Physical Health	2016 Total	2017 Behavioral Health	2017 Physical Health	2017 Total
BCBSNM	19	3	22	1,078	91	1,169	1,213	803	2,016	2,362	2,803	5,165	2,645	2,062	4,707
MHNM	7 *	0	7	1,909	32	1,941	2,132	754	2,886	3,579	98	3,677	4,213	219	4,432
PHP	2,016	4	2,020	5,006	143	5,149	5,809	134	5,943	5,045	280	5,325	10,119	180	10,299
UHC	89	22	111	1,046	96	1,142	1,833	236	2,069	1,786	1,000	2,786	4,664	1,944	6,608
TOTAL	2,131	29	2,160	7,039	362	7,401	8,987	1,927	10,914	12,772	4,181	16,953	21,641	4,405	26,046

* Most telehealth services provided in New Mexico are for behavioral health diagnoses.

In 2013, Medicaid behavioral health services were administered by OptumHealth New Mexico.

Source: MCO DSIPT Telemedicine Report

Transportation

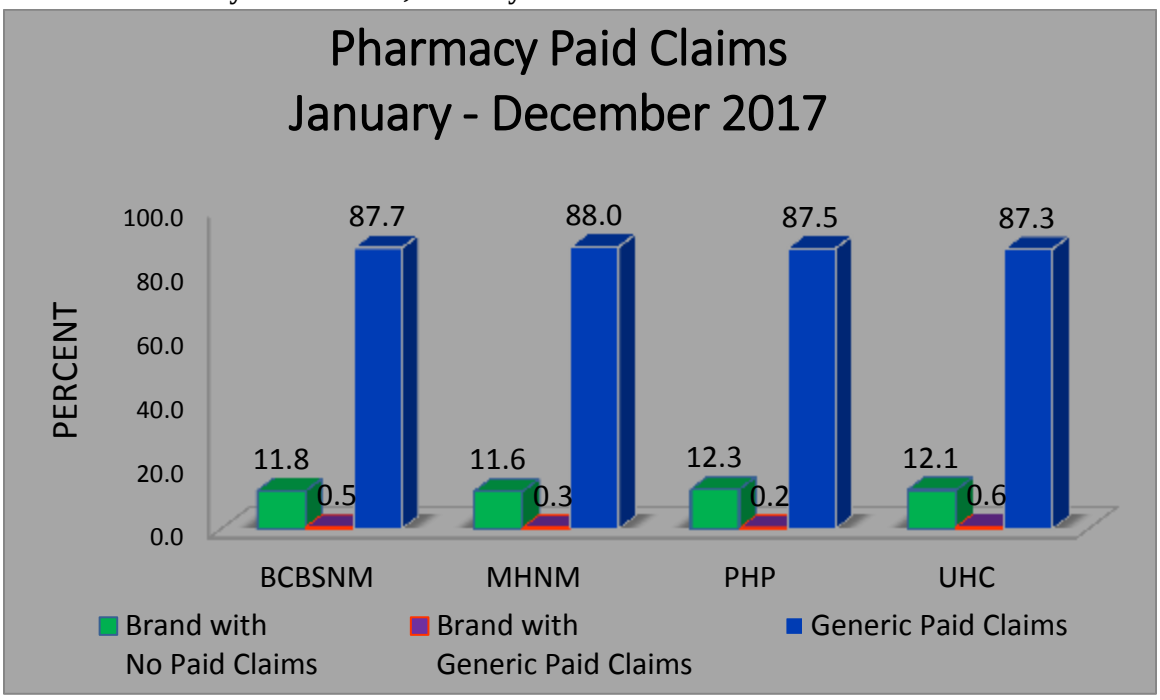
In DY4, all MCOs met geographic access standards for non-emergent ground transportation in urban, rural and frontier areas. Consistent with previous reporting Non-emergency medical transportation (NEMT) grievances have represented the highest percentage of total member grievances in DY4. Please see Complaints and Grievances for additional information.

Pharmacy

HSD monitors the MCOs' utilization of generic medication, brand with generic and brand with no generic. MCOs are required to use generic drugs when available and require medical justification for usage of brand drug use when a generic drug is available. In DY4, HSD identified the following:

- 87.6% average generic drug utilization for all four MCOs;
- 12.0% average brand with no generic available for all MCOs; and
- 0.4% average brand use with a generic drug available for all MCOs

Table 5 – Pharmacy Paid Claims, January – December 2017



Source: [MCO] Report #44, December 2017

In DY4, HSD continued to work on standardizing pharmacy reporting to ensure a consistent methodology is utilized across all MCOs that will allow for a more thorough analysis of pharmacy services. The revised report will continue to monitor claims data, prior authorizations, and therapeutic classifications as well as monitoring of drugs for the treatment of opioid dependence, alcohol and nicotine dependence, methadone use in pain management, HIV treatment, and utilization of antipsychotic medications in children.

Hepatitis C (HCV)

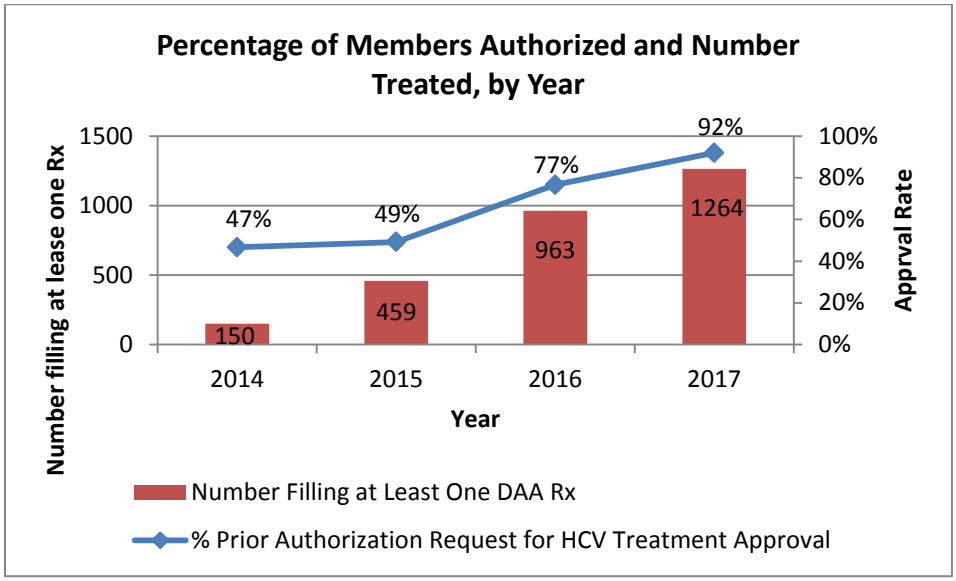
The DY4, HCV Delivery System Improvement Performance Target (DSIPT) was increased to 70% of their member-months, an increase from 50% in 2016. HSD continued to host quarterly meetings and work with the MCOs to support the HCV treatment delivery system and assure members' access to care. The group addressed issues related to screening, case finding, provider training, collaboration with the New Mexico Department of Health on data sharing, and many other issues. HSD worked with the actuarial contractor to provide the MCOs with a formula to estimate the HCV DSIPT based on the MCOs' monthly member enrollment. This enabled the MCOs to evaluate their own performance on a regular basis. By mid-September of 2017, all of the MCOs have asked and were approved to expand their treatment coverage to all adult members with chronic infection, regardless of fibrosis level.

In late 2017 HSD issued a Letter of Direction to the MCOs in order to clarify the Medicaid benefit coverage and expectations related to treatment of HCV. This letter directed the MCOs to expand the treatment criteria for all members over the age of 17 with active HCV infection (F0,

F1, F2, F3, F4, decompensated cirrhosis, and hepatocellular carcinoma). In addition, the MCOs were given specific instructions to reconsider previously denied HCV treatment requests using the new criteria as well as develop a provider incentive plan to expand the number of practitioners treating chronic HCV in New Mexico, including incentive(s) to receive training in the treatment of chronic HCV infection, incentive(s) to begin treating such patients, and incentive(s) for treatment of each patient.

HSD reviewed the MCOs' monthly HCV prior authorization reports and at year end compared prior authorization approval rates to the number of members filling at least one direct-acting antiviral (DAA) prescription. In 2017 there was a 92% approval rate for treatment, an increase from the 77% in the previous year. Additionally, preliminary analysis of the 2017 encounter data shows that there were 1,264 members that filled at least one DAA prescription. Please see Table 6: Percentage of Members Authorized for Treatment and Number Treated by Year.

Table 6 – Percentage of Members Authorized for Treatment and Number Treated by Year



Community Interveners

In DY4, there were five Centennial Care members who received Community Intervener (CI) services. The MCOs continue to provide education to their care coordinators to assist in identifying members that meet the criteria for the CI service. The MCOs also continue to provide assistance and resolution on billing issues to the CI providers as needed.

Table 7 – Consumers and Community Intervener Utilization

MCO	# of Members Receiving CI	Total # of CI Hours Provided	Claims Billed Amount
BCBS	2	988	$6,249
MHC	0	0	$0
UHC	2	678	$4,293
PHP	1	351	$9,156
Total	**5**	**2,017**	**$19,698**

Long-Term Services and Supports

Long-Term Care (LTC) Workgroup

The LTC Workgroup continued its activities in DY4. The LTC workgroup had many accomplishments in DY4 including but not limited to:

- Monitoring the implementation of the Community Benefit Services Questionnaire (CBSQ) through ride-alongs with care coordination and monthly MCO reporting of the number of completed CBSQs;
- Collaborating on the implementation of the CMS Final Settings Rule;
- Collaborating on LTC policy changes, including policies and procedures related to the statewide Electronic Visit Verification (EVV) System;
- Recommending improvements to the Functional Assessment Tool;
- Implementing a mandatory requirement for Self-Directed employees to use an online timesheet system;
- Implementation of a project that focused on the alignment of MCOs for dually eligible members; and
- Collaborating on the development of trainings for MCO staff.

Home and Community-Based Services Final Rule

In January 2017, HSD received initial CMS approval of its Statewide Transition plan. In late 2017, HSD in partnership with the Aging and Long-Term Services Department (ALTSD), conducted on-site provider reviews and participant surveys as required by CMS. HSD continues to update its Final Setting Rule milestones.

Training

In DY 4, HSD conducted several LTC related trainings with the MCOs that included the following topics:

- Allocating persons who are not otherwise Medicaid eligible to receive community benefits;

- Provider enrollment requirements for Personal Care Service (PCS) providers who want to also enroll as Respite providers;
- How to become a Centennial Care Community Benefit (CB) provider for CB services; and
- Prior authorization procedures, allowable services and provider policies and rules specific to Assisted Living Facilities.

Electronic Visit Verification (EVV)

The full implementation of an EVV system beginning in November of 2016 has proven successful, even in New Mexico's frontier and no-tech zone areas due to the seven day store and forward capability in the system. In DY4, MCOs and their subcontractors continued to provide assistance to PCS agencies with the EVV system, connectivity issues, and billing as needed. Many agencies have implemented new business practices and employee policies in order to come into compliance with EVV requirements. In DY4, HSD implemented a new reporting process with the MCOs to monitor ongoing EVV compliance.

HSD and the MCOs partnered with the New Mexico Association for Home Health and Hospice Care (NMAHHC) to provide information on the EVV system and discuss provider concerns at the Association's quarterly conferences. Providers appreciate this collaboration.

Centennial Rewards

The Centennial Rewards program was developed with the launch of Centennial Care as a way of providing incentives to members for engaging in and completing healthy activities and behaviors, including:

- **Healthy Smiles** to reward annual dental visits for adults and children;
- **Step-Up Challenge** to reward completion of a 3-week or 9-week walking challenge;
- **Asthma Management** to reward refills of asthma controller medications for children;
- **Healthy Pregnancy** to reward members who join their MCO's prenatal program;
- **Diabetes Management** to reward members who complete tests and exams to better manage their diabetes;
- **Schizophrenia and/or Bipolar Disorder Management** to reward members who refill their medications; and
- **Bone Density Testing** to reward women age 65 or older who complete a bone density test during the year.

Members who complete these activities can earn credits, which can then be redeemed for items in the Centennial Rewards catalog. All Centennial Care members are eligible for Centennial Rewards. To date, 685,460 distinct members, or 72% of all Centennial Care enrollees, have earned at least one incentive or reward. While the program just completed its fourth full year, data is not yet available for the fourth year. Three full years of data reflect members have earned points totaling a value of $51 million. The table below shows the healthy behaviors that have

been rewarded and each activity's value in dollars. It includes the maximum dollar value available for each activity and the total dollars earned.

Table 8 – Healthy Behaviors Rewarded

Reward Activities	Reward Value in Points, by Activity	Maximum Reward Dollar Value	Total Rewards Earned (Dollar Value)
Asthma Management	600	$60	$1,221,510
Bipolar Disorder Management	600	$60	$1,438,670
Bone Density Testing	350	$35	$66,465
Healthy Smiles Adults	250	$25	$10,597,350
Healthy Smiles Children	350	$35	$23,941,855
Diabetes Management	60	$60	$5,826,440
Healthy Pregnancy	1000	$100	$1,530,200
Schizophrenia Management	600	$60	$721,615
Step-Up Challenge	500	$50	$580,025
Health Risk Assessment*	10	$10	$4,394,170
Other (Appeals and Adjustments)	N/A	N/A	$646,548
Totals			**$50,964,848**

***HRA completion was discontinued as a rewardable activity at the end of CY2016**

The Step-Up Challenge remains the most popular activity offered through the Centennial Rewards program, with more than 90,000 members having registered for the Challenge and logged their steps to date. Data shows that participants in the Step-Up Challenge continue to show lower costs and improved quality across multiple indicators.

Overall, New Mexico's Centennial Rewards program has achieved over $100 million in savings since 2014, and participants across all conditions have shown 20% to 50% higher compliance with HEDIS-related scores. Participant costs were between 2.2% and 27% lower across all conditions, with reduced inpatient admissions and lower costs per admission among participants being the predominant driver behind cost savings. Notably, rates of behavioral health medication adherence exceed 80% among Rewards participants. The state has also seen overall increases in preventive screenings, high value PCP visits, and pharmacy refills among participants.

Participation in the Centennial Rewards program remains remarkably strong and is likely the highest participation rate for a program of its kind in the nation. Since the beginning of the program, there have been over one million visits to the Centennial Rewards member portal. Most importantly, member satisfaction has remained exceptionally high, with 96% of members reporting satisfaction with the Centennial Rewards program, and 97% reporting that the program has led them to making healthier choices.

Other Operational Issues

Contract Amendments

There was one amendment to the Medicaid Managed Care Services Agreement in DY4 Contract Amendment #7can be found on the HSD website at: http://www.hsd.state.nm.us/LookingForInformation/medical-assistance-division.aspx.

Adverse Incidents

HSD continues to meet quarterly with the Critical Incident (CI) workgroup in an effort to provide technical assistance to the MCOs. The workgroup supports the Behavioral Health Services Division (BHSD) on the delivery of BH protocols to providers. The protocols will be used by BH providers to improve accuracy of information reported and establish guidelines for the types of BH providers who are required to report. The Critical Incident Report (CIR) trainings are held annually to ensure providers have an understanding of reporting requirements.

Daily review of incident reports is conducted by the MCOs and the HSD CI unit. HSD continues to direct the MCOs to provide technical assistance when providers are non-compliant.

Critical Incidents are being reported quarterly by each MCO. One hundred percent of all critical incidents received through the HSD CI web portal are reviewed. This data is trended and analyzed by HSD.

During DY4, 17,756 critical incidents were filed for Centennial Care, Behavioral Health and Self-Directed members. Of the 17,756 reports filed, 4,094 reports were submitted in Q4; 4,261 in Q3; 4,597 in Q2; and 4,804 in Q1. MCOs have a multi-level educational process with internal and external collaborators to reduce inaccurate and un-timely submissions.

During DY4, a total of 1,743 deaths were reported. This is an increase from DY3 (1,698) and DY2 (1,433); however, the increase correlates with continued annual enrollment increases in the program. Of the 1,743 deaths reported, 1,574 deaths were reported as natural, expected deaths; 160 deaths were reported as unexpected; and nine were reported as suicides. All deaths reported through the critical incident system are reviewed by HSD and the MCOs.

All critical incident reports require follow up. Follow up can include medical record review, diagnoses or records from the Office of the Medical Investigator (OMI) to determine a cause of death. MCOs have internal processes to follow up on all deaths.

During DY4, Centennial Care, Behavioral Health and Self Directed populations reported a total of 11,464 (64.56%) critical incidents for Emergency Services. Of those Emergency Services reports, 963 were Behavioral Health related and 735 were for the Self-Directed population. MCOs collaborate with internal and external stakeholders to develop new practices to establish member contact in attempts to better serve the member. HSD will continue to monitor any decreases or increases of emergency services reports.

Table 9 – DY4 Critical Incidents

Critical Incident Types by MCO - Centennial Care										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	127	0.72%	387	2.18%	301	1.70%	292	1.64%	1,107	6.23%
Death	400	2.25%	410	2.31%	337	1.90%	596	3.36%	1743	9.82%
Natural/Expected	364		346		296		568		1,574	
Unexpected	36		60		38		26		160	
Suicide	0		4		3		2		9	
Elopement/Missi	17	0.10%	28	0.16%	43	0.24%	20	0.11%	108	0.61%
Emergency	2,366	13.33%	3,641	20.51%	2,409	13.57%	3,048	17.17%	11,464	64.56%
Environmental	37	0.21%	49	0.28%	81	0.46%	115	0.65%	282	1.59%
Exploitation	97	0.55%	125	0.70%	98	0.55%	188	1.06%	508	2.86%
Law Enforcement	62	0.35%	116	0.65%	66	0.37%	82	0.46%	326	1.84%
Neglect	395	2.22%	547	3.08%	581	3.27%	695	3.91%	2,218	12.49%
Total	**3,501**	**19.72%**	**5,303**	**29.87%**	**3,916**	**22.05%**	**5,036**	**28.36%**	**17,756**	**100.00%**

Critical Incident Types by MCO - Behavioral Health										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	36	2.00%	195	10.82%	77	4.27%	16	0.89%	324	17.98%
Death	6	0.33%	58	3.22%	9	0.50%	6	0.33%	79	4.38%
Natural/Expected	1		45		3		4		53	
Unexpected	5		11		4		2		22	
Suicide	0		2		2		0		4	
Elopement/Missi	9	0.50%	9	0.50%	18	1.00%	1	0.06%	37	2.05%
Emergency	56	3.11%	764	42.40%	98	5.44%	45	2.50%	963	53.44%
Environmental	2	0.11%	3	0.17%	8	0.44%	0	0.00%	13	0.72%
Exploitation	5	0.28%	17	0.94%	2	0.11%	1	0.06%	25	1.39%
Law Enforcement	10	0.55%	28	1.55%	15	0.83%	2	0.11%	55	3.05%
Neglect	21	1.17%	213	11.82%	41	2.28%	31	1.72%	306	16.98%
Total	**145**	**8.05%**	**1,287**	**71.42%**	**268**	**14.87%**	**102**	**5.66%**	**1,802**	**100.00%**

Critical Incident Types by MCO - Self Directed										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	11	1.08%	33	3.25%	44	4.33%	11	1.08%	99	9.75%
Death	12	1.18%	12	1.18%	21	2.07%	18	1.77%	63	6.21%
Natural/Expected	12		8		16		17		53	
Unexpected	0		4		5		0		9	
Suicide	0		0		0		1		1	
Elopement/Missi	0	0.00%	4	0.39%	3	0.30%	0	0.00%	7	0.69%
Emergency	113	11.13%	124	12.22%	359	35.37%	139	13.69%	735	72.41%
Environmental	0	0.00%	1	0.10%	2	0.20%	3	0.30%	6	0.59%
Exploitation	5	0.49%	7	0.69%	10	0.99%	11	1.08%	33	3.25%
Law Enforcement	6	0.59%	6	0.59%	7	0.69%	1	0.10%	20	1.97%
Neglect	8	0.79%	2	0.20%	23	2.27%	19	1.87%	52	5.12%
Total	**155**	**15.27%**	**189**	**18.62%**	**469**	**46.21%**	**202**	**19.90%**	**1,015**	**100.00%**

Action Plans

MCOs proactively initiate internal Corrective Actions Plans (CAPs) throughout the year to address areas of noncompliance or areas for improvement. In DY4, HSD monitored each MCO's

initiation, progress, and closure of CAPs, which were reported by the MCOs as follows: In Q1DY4, seven CAPs in progress and three closed; Q2DY4, seven CAPs in progress and two closed; Q3CY4, eight CAPs in progress and three closed; and Q4CY4, eight CAPs in progress and three closed. For additional details, a summary and progress updates are provided as an attachment with each quarterly report.

Evaluation Activities

Progress under the Centennial Care 1115 Waiver Evaluation Design Plan activities continued throughout DY4. Major activities consisted of: finalizing the data and report collection for the completion of the DY3 Annual Report; initiating the data collection process for DY4; development of timelines and contract deliverables for DY4; and initiating discussions on report content and structure of the Final Evaluation Report.

Various discussions were held between Deloitte and HSD's evaluation teams as well as key contacts across Centennial Care reporting divisions to appropriately address any changes in reporting methodologies or to identify new or additional data sources. Deloitte and HSD collaborated to streamline DY3 reporting activities to focus primarily on a review of the analyses performed on each hypothesis and goal. The process of assessing and monitoring progress consisted of analyzing a selected sample of the most relevant performance measures from the Evaluation Design Plan. This approach will provide for a more up to date view of the key analyses and results.

The principal milestone achieved during DY4 was the submission of the Interim Evaluation Report. The report provided detailed information related to the Centennial Care program design and goals, testable hypothesis and analysis, and findings of over one hundred performance measures to provide a basis for drawing conclusions on the effectiveness of Centennial Care.

The following provides a timeline of major activities related to the submission of the Interim Evaluation Report:

- May 1st, 2017: Initiation of Interim Evaluation Report outline drafting;
- July 7th, 2017: Completion of draft outline of Interim Evaluation Report;
- August 8th, 2017: On-site discussion with Deloitte evaluation team, HSD evaluation team and various subject matter experts across different Centennial Care reporting divisions;
- September 10th, 2017: Completion of draft Interim Evaluation Report
- October 13th, 2017: Submission of finalized Interim Evaluation Report to HSD

Interim Findings

During DY4, HSD's contractor completed the Centennial Care Interim Evaluation Report. Highlights from the interim evaluation, based on data through calendar year (CY) 2015 and preliminary CY2016 data, include:

- **Improving Access to Care –** The 1115 Waiver Evaluation noted mixed progress in timely access to care related to several measures as compared to the baseline2 of the Centennial Care program. Improvements were found in the percentage of state population enrolled in Centennial Care, the percentage of Native Americans opting into Centennial Care, the ratio of providers to members, increased access to telemedicine, the percentage of members utilizing newly available BH services (BH respite, family support, and recovery services), and the rate of flu vaccinations.

  Conversely, declines were found in the percentage of members who had an annual dental visit (although the rates across the cohorts are higher than the national averages), the number of adult members accessing preventive/ambulatory services, the percentage of members who had a PCP visit, the percentage of PCPs with open panels (though the overall percentage of open panels remained above 90%), breast cancer screening rates, cervical cancer screening rates, childhood and adolescent immunization rates, and prenatal and postpartum care, and the percentage of members utilizing mental health services (as indicated by their principal diagnosis)3. These declines represent potential areas for improvement in coming years, and in some cases were potentially affected by external factors such as the expansion of Medicaid and the continued influx of these members.

  It should be noted that a significant transition within the behavioral health provider network took place during 2015 (DY2). There was a concerted effort to rebuild the network which included supporting Federally Qualified Health Centers (FQHCs) with the expansion of their service offerings to cover behavioral health services through support of obtaining additional required certifications to offer these specialized services. While some gaps in the network existed for a time resulting in service delays, the efforts by New Mexico and other stakeholders helped to quickly resolve these issues and reduce the concern of future service delays or access limitations.

- **Improving Care Coordination and Integration –** The Evaluation indicated general progress in both care coordination and integration activities. Improvements were noted in the percentage of members the managed care organizations (MCOs) were able to engage, the percentage of members for whom Health Risk Assessments (HRAs) were completed, the percentage of Level 2 members who received telephonic and in-person outreach, the percentage of members who had a BH service and also received outpatient ambulatory visits, and the Emergency Room (ER) visit rates among members with BH needs.

There has been an increase in the number of unique members receiving Home and Community-Based services (HCBS), and an overall increase in HCBS provided. New Mexico continues to be successful in its rebalancing efforts with 84.6% of long-term care members receiving long-term services in their homes and 13.6% of members residing in nursing facilities.

Conversely, a higher percentage of LTSS members had ER visits, a lower percentage of members with schizophrenia or bipolar disorder received diabetes screening, a lower percentage of members with schizophrenia and diabetes received tests for diabetes monitoring.

- **Improving Quality of Care –** The Evaluation found continued improvements in quality of care. There were improvements in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screening ratios; increases in monitoring rates of Body Mass Index (BMI) for adults, children and adolescents; and increases in asthma medication management. Hospital admission rates also decreased across all five ambulatory care sensitive (ACS) measures. Finally, there was a decline in the percentage of ER visits that were potentially avoidable.

- **Reducing Expenditures and Shifting to Less Costly Services –** The Evaluation found that the program continued to demonstrate significant savings in comparison to the waiver budget neutrality threshold through DY3. Total program expenditures for DY3 alone were 21.8% below the budget-neutral limits as defined by the Special Terms and Conditions (STCs), which includes per member per month (PMPM) cost caps by MEG, uncompensated care costs, and Hospital Quality Improvement Incentive (HQII) pool amounts. The total cost of Centennial Care for DY1, DY2, and DY3 combined is below the budget neutrality limits as defined in the STCs4 by about $2.5 billion, or 15.8%.

  In addition, inpatient claims exceeding $50,000 as a percentage of healthcare costs were slightly lower. There were also decreases in hospital readmission rates, positive increases in the use of substance abuse services and use of HCBS, positive shifts in pharmacy utilization where usage of generic drugs is more prevalent than brand drugs, and positive shifts from higher level of care (LOC) Nursing Facility (NF) utilization to lower LOC NF utilization.

- **Increased Member Engagement** – There was a significant increase in the number of members enrolled in the Centennial Rewards program and performing various wellness-related activities designed to earn rewards under the program; at the end of DY1, approximately 47,000, or 7.1% of eligible members, were registered for the program. At the end of DY2, approximately 156,000, or 20.2% of eligible members were registered

for the program. There are over 40 activities members can perform to earn rewards from adhering to refilling monthly prescriptions to getting an annual dental visit. In all 40 categories, the percentage of members earning rewards (i.e. performing a health/wellness activity) increased through DY2.

Note that the Centennial Rewards program was a brand new program that required introductory member outreach for making members aware of the program and how to participate. It began April 1, 2014 and thus there were fewer months in DY1 in which members were able to register and participate in the program.

- **Increased Member Satisfaction –** The Evaluation found that member satisfaction results largely improved from the baseline to DY2. Measures that exhibited improvements included the percentage of expedited appeals resolved on time and the percentage of appeals upheld. Improvement was also noted in the number of appeals partially overturned and overturned, marked by decreases through DY2. Satisfaction rates for care coordination and customer service satisfaction rates also increased for members from the baseline to DY2.

  It is important to note that total Centennial Care member months increased from DY1 to DY3 by about 1,306,000, or 17.8%1. The vast majority of this increase was driven by Medicaid Eligibility Group (MEG) 6, (named "VIII Group"), which is the Medicaid adult expansion group. Enrollment in VIII Group grew by 63.3% from DY1 to DY3. Members eligible under this MEG are individuals at or below 133% federal poverty level (FPL) who are between ages 19 and 64 and who do not qualify for Medicaid under a previously implemented MEG (e.g. not disabled and not pregnant women).

Quality Assurance Monitoring Activities

Care Coordination Audits

HSD continues to monitor MCO monthly progress reports evaluating care coordination activities. These progress updates outlined the MCOs' efforts to improve care coordination practices according to HSD's recommendations and action steps from the November 2015 care coordination audit. The MCOs continue to implement internal processes to improve care coordination and provide training on accurate documentation as well as contract and policy requirements for their care coordination teams. HSD conducted a meeting with each MCO in July 2017 to discuss progress reports and review the evaluation results of MCO implemented care coordination interventions. The MCOs' internal audits for action steps and recommendations showed improvement and HSD closed out corrective action plans when the internal audit results evidenced substantial compliance for three consecutive quarters. HSD was pleased that all action steps and recommendations from the 2015 audit were completed for PHP during DY4. BCBS, UHC and MHC also had several action steps completed in DY4.

Additional audits were conducted in September 2017 for transition of care member file compliance as well as level of care coordination designation. HSD found with the transition of care audit that member files did not consistently contain all required information such as Medicaid eligibility status, disaster plan or identification of physical health, behavioral health or community needs. The results of these audits prompted HSD to issue additional action steps and recommendations to the MCOs which will be monitored monthly during DY5. Level of care audits found that some members who met criteria for care coordination level 2 or level 3 were not assigned to care coordination. In some instances this was due to those members being enrolled in the MCOs' Dual Special Needs (DSNP) plans for members with both Medicare and Medicaid eligibility. The DSNPs have specific care coordination requirements apart from Centennial Care. These issues have been addressed and follow up with members has been requested. HSD will continue to audit level of care coordination designation and conduct ongoing quarterly MCO meetings in DY5.

In June and August 2017, HSD provided additional training on accurate documentation, best practices and care coordination requirements to reinforce the areas targeted in the care coordination audits. Topics included consistency in care coordination touchpoints, best practices and tips for conducting Comprehensive Needs Assessments (CNAs) and Comprehensive Care Plans (CCPs) as well as tips on motivational interviewing techniques. Areas covered also included a discussion of the care coordination audit findings, review of the HSD policy and contract, aligning physical health and behavioral health needs identified from the CNA with the CCP goals, enhancing falls documentation, individualizing and distinguishing between backup plans and disaster plans, and effectively capturing on-going care coordination activities and member feedback. HSD received positive feedback that consistent and regular training assist their staff in maintaining a high level of quality in documentation and reinforcing excellent care coordination skills.

Care Coordination for Super Utilizers

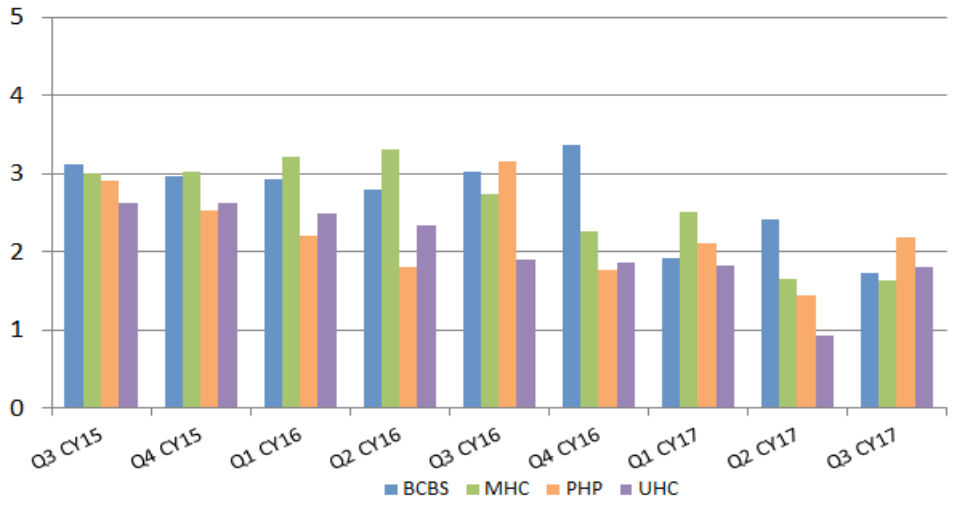
HSD utilizes PRISM software to track members who are high utilizers of the Emergency Department (ED) and works with the MCOs on implementing interventions to reduce unnecessary ED utilization.

- PRISM is an integrated software tool used to support care management interventions for high risk Medicaid patients.
- HSD utilized PRISM data to identify the MCOs' highest utilizers of the ED.
- In DY2, HSD began tracking the top ten members for each MCO. In DY3, HSD began tracking the top 35 super utilizers per MCO.
- During DY4 HSD monitored monthly reports on each "super utilizer" group, tracking the number of ED visits, supplemental care information and care coordination activities to reduce non-emergent ED utilization.

HSD provided feedback to each MCO targeting specific member issues, encouraging unique engagement efforts and working with MCO representatives to devise new methods to reach 'difficult to engage' members. Some of the new initiatives included:

- In DY4, UHC adapted a policy to consider all of its "super utilizer" members to be at care coordination level three with additional touchpoints, targeted interventions and increased attention to these member's needs. This policy, along with continued efforts by care coordinators, has shown success in reducing the average ED usage among members.
- BCBS has had success connecting with difficult to engage members through its regional peer support groups. In addition it has partnered with the New Mexico Hospital Association to assist in finding members who have been "unable to locate".
- In DY4, PHP began connecting with members at methadone clinics and reached over 100 members including "super utilizers" through having a presence at these locations. Using both peer support specialists and care coordinators and by varying the times staff were available, they had success in sharing resources and linking members to needed services.
- MHC successfully assisted several of its members to obtain housing by linking its housing support specialist to those super utilizer members in need. Once housing is secured, other aspects of care coordination are accomplished with more ease for the member.

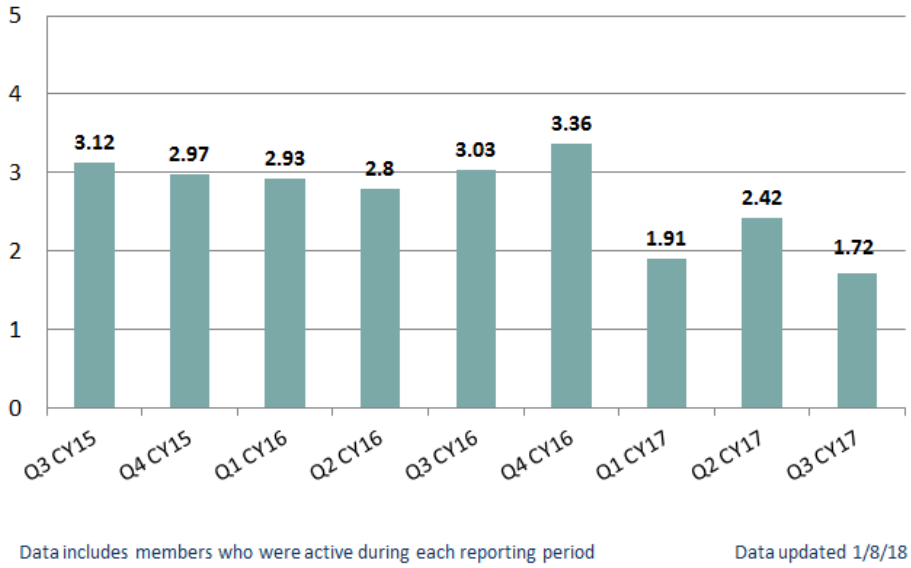
The following graph illustrates average quarterly ED visits for each of the MCOs' top 35 super utilizers.



Data includes members who were active during each reporting period

Data updated 1/8/18

The graph below illustrates the continued decline in average ED use over the period of the project-showing the average ED visits per member for all MCO's has fallen by 45%.



Other MCO efforts to reduce Non-Emergent Emergency Room Use

- Assigning Community Health Workers to high utilizers;
- Engaging members with Peer Support Specialists;
- Meeting members throughout the community for enhanced engagement;
- Utilizing EDIE software for instant notification when a member is in the ER;
- Including Housing Support Specialists to access housing opportunities for homeless members;
- Video physician visits continue to be utilized by all MCOs including access through smart phones;
- Working with local and regional agencies to connect with untapped resources; and
- Employing a team approach to include professionals from all areas to address members' unique needs.

Care Coordination and EDIE System

The Emergency Department Information Exchange (EDIE) is a MCO collaborative effort utilized to promote appropriate ED utilization. EDIE was launched in July of 2016 with additional hospitals and emergency facilities joining the effort throughout 2017. EDIE allows the MCOs to increase the impact of their existing care coordination resources by automatically aggregating a full census of all ED and inpatient admissions, transfers, observations and discharges. EDIE is directly integrated with the hospital Electronic Medical Record (EMR), which automatically alerts EDIE. EDIE then identifies the patient and references visit history, even if key information is missing from the patient's hospital record. If a visit triggers a pre-set criterion, EDIE notifies the provider within seconds. Notifications to the provider contain visit

history, diagnoses, prescriptions, guidelines, and other clinical metadata. As a result of the notification, the provider has information in hand before seeing the patient. This allows the provider to take action and to influence health care outcomes. Due to the increased use of EDIE, MCOs have reported continual incoming data that has allowed them to better assist those members utilizing ED, rapidly see those members with emergent needs and connect difficult to engage members with care coordinators. It is anticipated that this system will reduce the costs associated with unnecessary ED visits especially as more agencies participate. Currently there are 39 hospitals participating across the state. Targeted training of staff is being scheduled with some participating agencies and specific technical issues are being worked on with others. A standardized care plan is being looked at by committee members tasked for that purpose. HSD and all participants are confident that as more sites are launched, training is completed and standardized care plans implemented, more agencies will see the benefits of EDIE and the project will continue to grow.

Care Coordination for Incarcerated Individuals

HSD continues to provide technical assistance for a care coordination pilot project with MHC and the Bernalillo County Metropolitan Detention Center (BCMDC). The project focuses on providing incarcerated members with care coordination to address members' immediate healthcare needs upon release. HSD attends monthly meetings with BCMDC and MHC focusing on care coordination activities and member outcomes. Currently there are 366 members who have agreed to participate in this program. The number of participants has steadily increased throughout DY4 with the number of those referred and declining participation decreasing. MHC has worked closely with BCMDC to lower the number of participants who are missed due to early release and have been pleased to show that increased communication has that number currently at zero. Connecting with participants who are released and then difficult to engage has continued to be a priority for MHC. Care coordinators have been connecting with pharmacies and providers for updated participant information when recent claims have occurred. MHC has engaged more community connectors to locate members and identify and address any social determinants as a way to reengage members in care coordination services. A current challenge is understaffing at the BCMDC which is placing a temporary hold on new referrals to the project. On a positive note, BCMDC has broken ground on a re-entry center which HSD believes will assist members who are being released into the community. HSD foresees future expansion of corrections engagement throughout DY5.

Care Coordination Ride-Alongs

HSD continues to conduct "ride-alongs" with MCO care coordinators on a quarterly basis. In DY4, "ride-alongs" were conducted with all four MCOs with staff observing initial CNAs in member's homes. During DY4, HSD observed the interviewing styles of care coordinators, whether all the necessary information was gathered, and whether all resources and services were presented to members. HSD found that the care coordinator's activities were in compliance with contract requirements, including the administration of the Community Benefit Services

Questionnaire (CBSQ) and the CNA. Observations during future "ride-alongs" will inform what additional information may be included in DY5 care coordination training.

Service Plans

HSD continues to randomly review service plans to ensure 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. There were no identified concerns for DY4.

Table 10 – 2017 Service Plan Audit

Service Plans	Quarter 1 2017	Quarter 2 2017	Quarter 3 2017	Quarter 4 2017	DY4 Totals
Member files audited	120	120	120	120	480
Percent of service plans with personalized goals matching identified needs	100%	100%	100%	100%	100%
Percent of service plans that hours allocated matched need	100%	100%	100%	100%	100%

Nursing Facility Level of Care (NF LOC)

HSD reviews Nursing Facility High LOC denials and Community Benefit NF LOC denials on a quarterly basis to ensure the denials were appropriate and comply with NF LOC criteria. HSD was in agreement with all MCO NF LOC decisions for DY4. All NF LOC decisions were appropriate and complied with NF LOC criteria.

Table 11 – 2017 NF LOC Audit

	Quarter 1 2017	Quarter 2 2017	Quarter 3 2017	Quarter 4 2017	DY4 Totals
High NFLOC requests denied (and downgraded to Low NF)					
Number of member files audited	17	17	17	15	66
Number of member files that met the appropriate level of care criteria	17	17	17	15	66
Percent of MCO level of care determination accuracy	100%	100%	100%	100%	100%
Low NFLOC requests denied (Community Benefit)					
Number of member files audited	20	22	22	25	89
Number of member files that met the appropriate level of care criteria	20	22	22	25	89
Percent of MCO level of care determination accuracy	100%	100%	100%	100%	100%

The External Quality Review Organization (EQRO) for HSD reviews a random sample of MCO NFLOC determinations every quarter.

Table 12 – 2017 EQRO NF LOC Review

Facility Based	Quarter 1 2017	Quarter 2 2017	Quarter 3 2017	Quarter 4 2017	DY4 Totals
High NF Determination					
Number of member files audited	29	27	23	28	107
Number of member files the EQRO agreed with the determination	24	24	22	27	97
%	83%	89%	96%	96%	91%
Low NF Determination					
Number of member files audited	79	81	85	80	325
Number of member files the EQRO agreed with the determination	77	81	85	78	321
%	97%	100%	100%	98%	99%
Home and Community Based					
Number of member files audited	156	156	156	156	624
Number of member files the EQRO agreed with the determination	155	154	153	153	615
%	99%	99%	98%	98%	99%

HSD reviewed NF LOC determination disagreements from EQRO audits from DY4 and was in agreement with all of EQRO findings. Issues identified included: conflicts in documentation, incomplete supporting documentation, and supporting documentation dated outside the required time period. HSD reviewed determinations with the MCOs through technical assistance calls for Q1 and Q2 and via deliverable in Q3 and Q4. All four MCOs provided clarification regarding identified issues and reviewed their internal procedures to monitor quality and plans moving forward to further improve accuracy. HSD noted that the MCO High NF determinations improved over the course of DY4 with the EQRO in agreement with 96% of the determinations in Q3 and Q4 compared to 83% in Q1 and 89% for Q2. MCO HNF determinations totaled 91% for DY4. The MCO Low NF determinations did not go below 97% during DY4 and achieved 100% in Q2 and Q3. MCO Low NF determinations totaled 99% overall for DY4. Community based determinations consistently totaled 98-99% for EQRO agreement and overall determinations totaled 99% for DY4. HSD will continue to monitor the EQRO audit of MCO NF LOC determinations and identify and address any trends and provide technical assistance as needed.

Post Award Forum

Beginning in Q4DY3 and throughout DY4, HSD solicited public input about the Centennial Care program in a wide variety of ways. At the end of DY3, HSD created a subcommittee of the

Medicaid Advisory Committee (MAC) to provide input on areas of improvement for the program. The MAC subcommittee met from October 2016 through February 2017 and the Native American Technical Advisory Committee met during the months of December 2016 through April 2017 to develop recommendations for improving Centennial Care. The input from both committees was utilized to develop New Mexico's concept paper for its renewal of the 1115 waiver that authorizes the program, which was released in May 2017. In addition, HSD made improvements to the program that could be implemented without waiver authority and through MCO contractual requirements that are effective on January 1, 2018. In April and October 2017, full MAC meetings were held to solicit public input on Centennial Care as well as for feedback about the changes outlined in the waiver renewal concept paper (April) and in the draft 1115 waiver renewal application (October).

Between May and October 2017, public input regarding Centennial Care was submitted via email, phone, or mail. In June of 2017, HSD staff traveled to different geographical areas of the state to solicit public feedback about the program. Advance newspaper notice was provided to advertise the events. In October 2017, HSD conducted four public hearings in different geographical areas of the state to solicit public input about Centennial Care and the changes to the program proposed in the draft 1115 waiver renewal application Advance newspaper notice was provided to advertise those events. During the months of June and October 2017, HSD also conducted two formal Tribal Consultations regarding the 1115 waiver renewal including proposed programmatic changes. Please see Attachment F: Public Comments Summary and Response. Note that the attachment includes a summary of the comments submitted during the formal public hearings but does not include the entire year-long compilation of public feedback which is contained in a large Excel file.

Table 13 - Summary of Public Input Process for 1115 Waiver Renewal Application

Event	Dates
Planning and Design Meetings:	
Subcommittee of the MAC Meetings	
• Santa Fe	October 14, 2016
• Albuquerque	November 18, 2016
• Santa Fe	December 16, 2016
• Albuquerque	January 13, 2017
• Santa Fe	February 10, 2017
NATAC Meetings	
• Albuquerque	December 5, 2016
• Albuquerque	January 20, 2017
• Santa Fe	February 10, 2017
• Albuquerque	April 10, 2017

Event	Dates
MAC Meetings (All meetings held in Santa Fe)	November 14, 2016 April 3, 2017 October 16, 2017
Publish Date - Concept Paper	May 19, 2017
Gather Feedback - Concept Paper Statewide Public Input Sessions • Albuquerque • Silver City • Farmington • Roswell	 June 14, 2017 June 19, 2017 June 21, 2017 June 26, 2017
NATAC Meeting (Albuquerque)	July 10, 2017
MAC Meeting (Santa Fe)	July 24, 2017
Formal Tribal Consultation (Albuquerque)	June 23, 2017
Notice Period - 60-day advanced notification to Native American / Tribal stakeholders regarding 1115 waiver renewal application	August 31, 2017
Publish Date - Draft 1115 Waiver Application	September 5, 2017
Gather Feedback - Draft Waiver Application Public Hearings & Tribal Consultation Meeting sites: • Public hearing: Las Cruces • Public hearing: Santa Fe (MAC meeting) • Public hearing: Las Vegas • Tribal consultation: Santa Fe • Public hearing: Albuquerque	 October 12, 2017 October 16, 2017 October 18, 2017 October 20, 2017 October 30, 2017
Final Waiver Application Submission to CMS	December 5, 2017

SECTION III: TOTAL ANNUAL EXPENDITURES

Table 14 – Waiver Year 4 Expenditures

Medicaid Eligibility Group (MEG)	Program Expenditures	Administrative Expenditures
MEG01 - TANF & Related	$ 1,431,162,319	$ 72,935,913
MEG02 - SSI & Related - Medicaid Only	$ 839,861,416	$ 7,917,402
MEG03 - SSI & Related - Dual Eligible	$ 552,047,932	$ 7,362,093
MEG04 - "217 Like" Medicaid Only	$ 12,410,795	$ 75,896
MEG05 - "217 Like" Dual Eligible	$ 111,430,661	$ 648,379
MEG06 - VIII Group - Medicaid Expansion	$ 1,418,096,328	$ 58,788,989
MEG07 - CHIP	$ 103,055,034	$ 10,593,709
Uncompensated Care "UC" Pool	$ 51,666,993	N/A
Hospital Quality Improvement Incentive "HQII" Pool	$ -	N/A
Grand Total	**$ 4,519,731,478**	**$ 158,322,381**

Source: New Mexico CMS 64 Submission, FFY18 Quarter 1, February 7, 2018

SECTION IV: YEARLY ENROLLMENT REPORT

Table 15 – Demonstration Year 4 Enrollment

Demonstration Population		
	DY4 Member Months (as of 1/2/18)	DY4 Enrollment (as of 1/2/18)
Population 1 – TANF and Related	1,121,156	373,808
Population 2 – SSI and Related – Medicaid Only	117,287	39,238
Population 3 – SSI and Related – Dual	105,472	35,984
Population 4 – 217-like Group – Medicaid Only	1,152	371
Population 5 – 217-like Group – Dual	9,866	3,461
Population 6 – VIII Group (expansion)	755,981	271,084
Totals	2,110,914	684,708

Note: This data was extracted on January 2, 2018. Due to retro-active eligibility, member months continue to increase slightly after the end of the waiver year.

SECTION V: MANAGED CARE DELIVERY SYSTEM

Accomplishments

Centennial Care Improvements

- The primary care provider-to-member ratio standard of 1:2,000 was met by all MCOs in urban, rural, and frontier counties.
- In collaboration with HSD, MCOs identified opportunities to improve encounter reporting and performance. MCOs enhanced system capabilities to remediate identified defects and developed process flows to map all data processing points including claims processing, encounter submission, and HSD encounter acceptance.
- MCOs are collaborating with paramedics to target high utilizers of 911 services, Emergency Department (ED) services, and those recently discharged, in order to re-engage these members in care coordination, provide education on preventive care and chronic conditions, promote the utilization of appropriate physical and behavioral health services, and reduce non-emergent ED visits. Some of these programs include, but are not limited to: Community Paramedicine and Santa Fe Fire Department Pilot Program. MCOs continue to utilize telemedicine to provide access to specialty providers and behavioral health providers especially for those members residing in rural and frontier geographic locations. As an example, one MCO implemented virtual physician visits. Members have access to board-certified doctors, psychiatrists, or licensed therapists that can help treat conditions such as allergies, asthma, cough, anxiety, and several other conditions. Access is available twenty-four hours a day, seven days a week and the average wait time is less than ten minutes.
- MCOs were directed to expand the treatment criteria for members with active Hepatitis C Virus (HCV) infection to include all members with active HCV infection for three months. MCOs were to reconsider previously denied HCV treatment requests using the new criteria. Additionally, each MCO was directed to develop a provider incentive plan to expand the number of practitioners treating chronic HCV in New Mexico.

Report Revisions

HSD revises reports to streamline elements from various reports, improve monitoring of MCO performance, and incorporate requirements of the managed care final rule, etc. The report revision process is initiated through a formal written process in which HSD and MCOs request needed changes to data elements. A revision workgroup to include subject matter experts (SMEs) is developed for each report revision to ensure the needs of all stakeholders are considered.

Improved Reporting Process

HSD utilizes MCO reports to monitor contract compliance. In DY4 the MCOs continued the Technical Assistance (TA) Calls and the Self-Identified Error Resubmission. These two

processes allow HSD and MCO SMEs to clarify data requirements and correct data inaccuracies. HSD is dedicated to obtaining accurate, complete and uniform data elements as the information received from the MCOs is used for a variety of analyses including state budget, legislative reports, and external stakeholder meetings.

Health Homes

On April 1, 2016 HSD launched the first two Health Homes, CareLink NM (CLNM), with a designated population of adults with serious mental illness and children/adolescents with severe emotional disturbance. The CLNM model provides for enhanced care coordination and integration of primary, acute, behavioral health, long term care services and social supports. Goals include: 1) Promoting acute and long term health; 2) Preventing risk behaviors; 3) Enhancing member engagement and self-efficacy, 4) Improving quality of life for members with SMI and SED; and 5) Reducing avoidable utilization of emergency department, inpatient, and residential services. These goals serve as the foundation for establishing both quality process standards and evaluation criteria for outcomes.

The initial provider base was restricted to two rural counties so processes could be tested, evaluated, and refined. MCOs and HSD staff including Medical Directors, quality experts and other leadership formed the CLNM Steering Committee with responsibilities for design approval, provider application processing and approval, and support and oversight.

The development of the automated information system, BHSDStar, was activated on April 1, 2017 and launched with data modules for registration, service planning and documentation, and interfaces to the Medicaid and MCO claims systems. Since then, the comprehensive needs assessment portion of the system has been finalized, a provider referral module is being developed, and a variety of system enhancements requested by providers have been implemented. Reporting functions have been developed and are being enhanced.

Delivery System Improvement Performance Targets (DSIPTs)

The DSIPTs allow MCOs to be recognized for their quality improvements in specific areas. In DY1 and DY2, HSD required four target areas for DSIPTs. In DY3, HSD expanded target areas by adding emphasis on five specific areas. HSD is currently evaluating the 2017 MCO results for DSIPT targets for DY4, which allows recognition of quality improvements, in the following five areas:

A. *Community Health Workers* – Increase the use of Community Health Workers (CHWs) with continued development of the workforce, 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 Worker 2017 Results - In 2017 a total of 53,913 MCO members were served by CHWs for a total increase of 28 percent. Each MCO utilized CHWs to expand services well above the 10 percent goal of members served. The goal for 2018 will be a 10 percent increase in members served.

B. *Patient Centered Medical Home* - A minimum of 5% increase of members being served by Patient Centered Medical Homes (PCMHs) or maintain a minimum of 45% of membership being served by a PCMH (including both PCMHs that have achieved NCQA accreditation and those that have not).

Patient Centered Medical Homes 2017 Results - PCMH membership in 2017 equals 316,211 members. All MCOs met their respective target by increasing PCMHs by 5% or maintaining a minimum of 45% of members served by PCMHs.

C. *Hepatitis C* - During DY4 contract period, MCOs must meet at least 70% of the MCO's target number of patients receiving Hepatitis C drug treatments for the combined Physical Health, Medicaid Only LTSS, and Other Adult Group populations.

Hepatitis C 2017 Results - As of February 2, 2018, utilizing the 2017 encounter data available to date, the preliminary target number of members to be treated was 1,197 for all MCOs and an estimated 1,264 members have been treated; hence, the overall MCOs' treatment number exceeded the target. HSD will be working with the encounter data at a later date when encounters are more complete to evaluate each MCO's performance.

D. *Value Based Purchasing* – In 2017 MCO's must meet a minimum of 16% of payments in VBP arrangements. Additionally at least 3% of the required 16% must be with high volume hospitals and require a readmission reduction target of at least 5% of the hospitals baseline.

Value Based Purchasing 2017 Results – All four MCO's have met the minimum of 16% of payments in VBP arrangements and the 3% requirement with high volume hospitals. One MCO has met the readmission reduction target. Final reporting will be submitted to HSD on May 15, 2018. Since the reporting is based on paid claims, HSD has allowed the MCO's to have a runout that matches the current runout on Financial Reporting.

E. *Telemedicine* - A minimum of a 15% increase in telemedicine "office" visits with specialists, included Behavioral Health providers, for Members in Rural and Frontier areas. At least five percent of the increase must be visits with BH providers.

Telemedicine 2017 Results – Utilization of telemedicine continues to increase. For 2017, there was a total of 26,046 telemedicine visits for all MCOs with 4,405 physical health telemedicine visits and 21,641 behavioral health telemedicine visits, which results in an average total increase of 53.6% from 16,953 in DY3. Three of the four MCOs met their respective target by increasing telemedicine by fifteen percent.

Community Health Workers

In DY4, all four MCOs included the use of Community Health Workers (CHWs) to serve a diversity of ethnic groups in the state's rural, urban, and frontier settings. New Mexico's CHWs are trained to address the Social Determinants of Health needs to improve health outcomes, by offering culturally appropriate education to address barriers to care, teach skills to manage treatment or prevent disease, along with linking individuals to health and social systems. The CHWs also work to inform the clinical care team of the identified need for Social Determinates of Health.

In DY4 HSD required CHW workforce data to include CHWs employed or contracted, for the purpose of tracking workforce development. All MCOs completed DY4 with a total of ninety-one (91) CHWs. The DY4 reported increase of 32 percent includes CHWs employed by and those contracted with the four MCOs. Please see Table 16: Year-over- year growth of the CHW workforce.

Table 16 – Year-over-Year Growth of Community Health Workers

	1st Year CY16	2nd Year CY17		
	2016 YTD Total	2016 YTD Total		
	Total	Employed	Contracted	Total
BCBS	ND	13	12	28
MHC	32	26	0	22
PHP	5	9	9.5	18
UHC	32	12	0	23
Total	69	60	21.5	91

Source: [MCO] DSIPTs, DY4

Training includes state-endorsed certification programs through community colleges. Approximately 103 participants have already completed the community college-based trainings, with additional participants going through the year-long training. Many have obtained tuition scholarships through Health Resources and Services Administration (HRSA).

An example of the diversity of the CHW workforce is seen in the UNM-Taos training program enrollees:

- 100 percent were eligible for tuition awards
- Represent educationally disadvantaged backgrounds
- 81 percent are originally from Northern New Mexico
- 94 percent identify as either Hispanic or Native American

    - Native American tribes represented included San Ildefonso Pueblo, Picuris Pueblo, Taos Pueblo, Navajo Nation, and Jicarilla Apache Nation
- Ages range from 19-63
- Two veterans
- Three referred by local GED/ESL program instructors

Social Determinates of Health screening informs the interventions needed by Medicaid recipients, and is central to the Integrated Primary Care and Community Support (I-PaCS) model used in DY4 by the HSD and the University of New Mexico Health Sciences Center Office for Community Health (OCH) and the Center for Health Innovation (SWCHI).
Social Determinates of Health include: housing, food security, transportation, utilities, personal safety, childcare, income, employment, education, substance abuse concerns, and legal/immigration assistance.

Some of the types of interventions resulting from the assessments include:

- Identifying community-based providers and services.
- Assisting members directly in making appointments to social services agencies.
- Checking EMR for recommended medical screening, pending lab tests or referrals.
- Medicaid, income support, SNAP, housing, or other government programs and services paperwork assistance.
- PCP engagement, by making appointments and setting up transportation.
- Chronic disease management.
- ED alternatives for non-emergent care.
- Nurse Advice line education.
- NM Crisis and Access Line education.
- Urgent Care education.

One of the metrics used by the I-PaCS model to determine the type of intervention(s) required by recipients is whether they had two or more emergency department visits in the last twelve months. Of the 781 recipients surveyed, 319 screened positive for this determinant, with a range of 2-20 visits in the past twelve months. Educating Medicaid recipients on appropriate use of the emergency department, sharing urgent care sites with them, and connecting them to primary care is a key element of the I-PaCS model, which results in reduced healthcare costs and improved health outcomes.

In DY4 interventions frequently include food assistance, utility assistance, transportation to appointments, and on-going health education and support. Please see Table 17: Year-over-Year Unduplicated Members. An increase of 5 percent was reported from the baseline year of CY15 to CY16. An 80 percent increase of Medicaid recipients is reported in CY17 as a result of the successful development of the CHW initiative by the MCOs.

Table 17 – Year-over-Year Unduplicated Members

	Baseline		1st Year CY16		2nd Year CY17				
	2015 Unduplicated Members Served	2016 Baseline Target 5% Increase	2016 YTD Total	2017 Baseline Target 10% Increase	Q1	Q2	Q3	Q4	2017 YTD Total
BCBS	20,714	21,750	27,736	30,509	1155	16,582	11,234	4,813	33,784
MHC	3,138	3,295	5,822	6,404	954	2,632	1,783	2,886	8,255
PHP	2,000	2,100	3,822	4,204	1171	1,731	1,167	1,317	5,386
UHC	2,600	2,730	3,730	4,103	2598	1,300	1,281	1,309	6,488
Total	28,452	29,875	41,110	45,220	5878	22,245	15,465	10325	53,913

Source: [MCO] DSIPTs, DY4

Utilization Data

Centennial Care key utilization and cost per unit data by overall program as well as by specific program for DY3 and DY4 can be found in Attachment G: Key Utilization/Cost per Unit Statistics by Major Population Group.

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. 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 MCOs to include the 14 additional questions outlined below that were approved by the National Committee Quality Assurance (NCQA) on the CAHPS survey for 2017. To review CAHPS results, please visit the HSD website at: http://www.hsd.state.nm.us/LookingForInformation/2016-cahps-reports.aspx.

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?
2. In the last 6 months, who helped to coordinate your child's care?
3. How satisfied are you with the help you received to coordinate your child's care in the last 6 months?
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?
5. In the last 6 months, who helped to coordinate your care?
6. How satisfied are you with the help you received to coordinate your care in the last 6 months?
7. In the last 6 months, have you received any material from your health plan about good health and how to stay healthy?
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?

9. Did your care coordinator sit down with you and create a plan of care?
10. Are you satisfied that your care plan talks about the help you need to stay healthy and remain in your home?
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?
12. Did you Fall in the past 6 months?
13. In the past 6 months, have you had a problem with balance or walking?
14. Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking?

Annual Summary of Network Adequacy by Plan

HSD evaluates and provides feedback to each MCO on their respective annual Provider Network Development and Management Plan that retrospectively evaluates the prior year and the coming year. The MCOs' plans must be sufficient to ensure that all medically necessary covered services are accessible and available for the current and new population, as well as assess the current unmet needs and future needs related to membership changes.

MCOs utilize Report #3, the Network Adequacy Report, to evaluate provider ratios, Report#53 Primary Care Provider (PCP) to evaluate PCP member ratios, open panels and change activity, and Report #55, the GeoAccess Report, to evaluate distance requirements to providers as key elements to inform their decisions. HSD tracks the progress of each MCO in meeting GeoAccess standards quarter-over-quarter and focuses on improvements to distance requirements where standards are not being met. Please also see Attachment D: 2016-17 GeoAccess PH All MCOs.

See Section II. for additional information on provider access.

Summary of Outcomes of Reviews and Focused Studies

Service Plan Reductions Audit

HSD continues to review a sample of service plan reductions for legacy members who had HCBS services under a section 1915(c) waiver and continued to meet the NFLOC criteria upon transition to the 1115 waiver, Centennial Care. HSD identified a universe of the legacy members who transitioned from the 1915(c) waivers to the MCO Community Benefits in the 1115 waiver. The MCOs were directed to submit a universe of members who had a reduction in Personal Care Service (PCS) hours during Calendar Year 2016 and HSD selected a random sample of 30 charts from each MCO to review.

BCBS audits revealed the reduction in PCS hours in 27 of the 30 files were appropriate and included reasons such as member improvement, increases in natural supports and shared households. HSD reviewed the results of the audit with BCBS and sought additional information

for the 3 remaining member files. BCBS provided the requested documentation, which included corrected allocation tools referenced in the UM notes for 2 of the files and the CNA and allocation tool associated with the time before reduction for the remaining file. After review of the documentation, HSD determined that the reduction in hours was appropriate for the 3 files in question.

MHC audits revealed the reduction in PCS hours in 26 of the 30 files were appropriate and included reasons such as member improvement, increases in natural supports and shared households. HSD sought clarification for the 4 remaining files, which lacked documentation necessary to review the reduction decision. MHC provided the requested documentation and after review HSD was in agreement that reductions for the 4 remaining files were appropriate.

PHP provided 30 member charts for review and the audit revealed that 28 of the 30 were appropriate and included reasons such as member improvement, increases in natural supports and shared households. Two of the member charts contained insufficient documentation to complete the review. HSD reached out to PHP for additional supporting documentation, which was provided. HSD reviewed the information and determined that reductions in in these two files were appropriate.

UHC also submitted 30 member files for review. 12 of the 30 files revealed the reduction was related to member improvement, increased natural supports, or shared living space. UHC also had 5 audit files which did not reveal a reduction in PCS hours. The remaining 13 member audit files did not have documentation demonstrating any correlation between the members' unchanged condition, supports or housing with reduction in PCS hours. HSD requested that UHC provide an analysis for the remaining 13 members. Of the 13 files that HSD sought clarification: 3 were reduced due to reassessment indicating increased natural supports or independence with ADLs; 3 members received reductions based on assessment but the reductions were overturned in fair hearings; 2 member's hours were decreased based on assessment and both reductions were upheld on appeal; 3 members received a reduction based on assessment indicating fewer ADL needs; 1 member's hours were reduced after a requested environmental modification was completed and reassessment indicated that member required less hours; and 1 member's hours were temporarily increased based on caregiver needs and then returned to previous amount which UHC noted was outside their standard process. HSD reviewed the analysis and accepted their response. HSD presented specific feedback to UHC to provide further detail and documentation regarding ADL's and to provide clear reasons why PCS hours were reduced. In response UHC noted that care coordinators will receive ongoing education on criteria for PCS determinations and appropriate documentation of ADL/IADL needs. This includes education by its Long Term Care Medical Director. Incomplete/Inadequate documentation within an assessment will result in a request for reassessment, mentoring and review by the care coordinator's manager. UHC reported that 9 of these 13 legacy members transitioned into Centennial Care with their previous hours and UHC 'administratively continued' allocated hours until the reassessment date for affected 2016 service hours.

HSD reviewed the results of the audits with each MCO and provided general recommendations for quality improvement for documentation related to PCS reductions. HSD also requested the process from each MCO regarding improvement of accuracy of determinations.

BCBS noted that each Utilization Management (UM) nurse has regular, monthly file audits conducted and confirmation/verification of appropriateness of reviews is a component of those audits. BCBS also revealed that both the medical directors and the UM staff are required to take annual inter-rater reliability tests, which may be inclusive of scenarios involving a reduction of PCS hours. Any concerns identified on audit are addressed with the UM reviewer and applicable coaching is provided.

MHC informed HSD that continuous training to improve accuracy and consistency of determinations for the UM staff remains a priority. Care coordinators have recently received refresher training on documentation requirements to ensure that any changes in health are appropriately documented in the file. Oversight of any decreases will be reviewed with supervisors to ensure documentation clearly reflects the reason for such changes. Supervisors also conduct regular audits of their staff allowing for feedback and improvement regarding decision-making, documentation and to address areas where there seem to be trends of staff needing more information or training.

PHP stated that to ensure accuracy of determinations, they are implementing monthly audits of the UM Reviewers, and Medical Director rounding with UM staff. Additionally, they will continue to host monthly team meetings during which training is provided.

UHC response noted that in addition to the activities stated above, PCS Regulations and MCO Policy Manual PCS Criteria and Assessment for Services are reviewed by the secondary review team (SRT) at least quarterly followed by an inter-rater (IRR) exercise. Peer to Peer review, as well as manager review, is utilized by SRT to validate decisions with significant decrease to member hours. UHC also notes that a formal documented IRR evaluation is conducted with all SRT members involved in PCS determination annually through their online learning application LearnSource. All team members must pass with 80% or greater. If a passing score is not obtained, remediation by the manager and a re-testing scenario is used to ensure competency.

HSD directed all four MCOs to continue training on clear, concise, and comprehensive documentation for member records.

Table 18 – DY4 Service Plan Reduction

Service Plan Reduction	BCBS	PHP	Molina	UHC
Number of member files audited	**30**	**30**	**30**	**30**
Number of files with inappropriate reduction	0	0	0	3*
Number of files with no reduction or increase	0	0	0	5
Number of files which showed an increase	0	0	0	0
Number of files with appropriate reduction	30	30	30	22

***Overturned in the fair hearing process**

Myers & Stauffer Evaluation

Myers and Stauffer, LC provided final reports of its audit findings for 2015 inpatient paid and denied hospital claims (including claims adjudication, prior authorization and provider credentialing) to HSD in March 2016. HSD evaluated Myers and Stauffer findings related to MCO policies and processes. Each MCO responded to HSD regarding the audit findings. HSD issued notice of a formal directed corrective action plan (DCAP) to UHC on August 18, 2016 and all DCAP items were closed on August 7, 2017. For further details concerning the DCAP and closure, please refer to the Q2DY2 Quarterly Report.

HSD has re-engaged Myers & Staffer to conduct an audit on Nursing Facility, Behavioral Health, and Hospital claims processing and payment, prior authorization, contract loading, and related policies and procedures for the timeframe July 1, 2016 through June 30, 2017.

Summary of Performance Improvement Projects

HSD required each MCO to implement four (4) Performance Improvement Projects (PIPs) in CY16. The MCOs designed each PIP to meet the unique needs of the MCOs' members, to ensure sustainable improvements and interventions, and to focus on quality improvement.

Pursuant to the Centennial Care Contract, two MCO PIPs focused on the following areas:

1. Services to Children
2. Long Term Care Services

Within the domains listed above, the MCOs developed each PIP to target relevant clinical or non-clinical services within the MCOs' specific populations as long as the focus was on the services provided within each domain. The MCO selected the study topic, study population, and study indicators. In addition, the MCO determined the sampling methodology and data collection process that would be used for analysis and interpretation.

In addition, the MCOs were directed to continue with the Quality Improvement Projects (QIPs) associated with the Adult Medicaid Quality Grant (AMQG) which expired in December 2015. The MCO developed two PIPs within the HSD selected domains to target the prescribed indicators as listed below:

3. Prevention and enhanced disease management for diabetes
    - Diabetes, short-term complications admission rate
    - Comprehensive diabetes care: HbA1c testing

4. Screening and management for clinical depression
    - Antidepressant medication management
    - Screening for clinical depression and follow-up plan

CMS requires an annual External Quality Review (EQR) of the MCOs contracted with the State. The review validates the PIPs developed by the MCOs and applies the review standards detailed in EQR Protocol 3 published by CMS. The protocol specifies the process that is used to assess the validity and reliability of the PIPs developed by the MCOs.

HealthInsight New Mexico is the External Quality Review Organization (EQRO) contracted to conduct EQR of PIPs submitted to the State by the MCOs. HealthInsight followed the CMS EQR Protocol 3, validated the PIPs and completed the reviews.

Table 19 – CMS-Defined 10 Step Process for Validating PIPs

CMS-Defined 10 Step Process for Validating PIPs	
1. Review the study topic	6. Review data collection procedures
2. Review the study question	7. Review data analysis and interpretation of study results
3. Review identified study population	8. Assess the MCOs improvement strategies
4. Review indicators	9. Assess the likelihood that reported improvement is "real" improvement
5. Review sampling methods	10. Assess sustainability of the documented improvements.

During 2017, the EQRO made the determination that each MCO is compliant with Centennial Care contractual and regulatory requirements for PIPs implemented by each MCO for the 2016 review.

Table 20 – PIPs by MCO for 2016

BCBS	MHC	PHP	UHC
Attention to Dental Health for Children	Improvement of Well Child Check Measure	Services to Children: Annual Dental Visit	Annual Pediatric Dental Visits
Long-Term Care: Diabetic Eye Exams	Fall Risk Factors and Services Referrals for Long Term Services and Supports	Inter-Rater Reliability (IRR) for Personal Care Services Allocation	Nursing Facility Transition
Diabetes Prevention and Enhanced Disease Management	Diabetes Prevention and Enhanced Disease Management	Diabetes Prevention and Enhanced Disease Management	Diabetes Prevention and Enhanced Disease Management
Screening and Management for Clinical Depression	Screening and Management for Clinical Depression	Screening and Management for Clinical Depression	Screening and Management for Clinical Depression

BCBS

PIP#1- Attention to Dental Health for Children: This PIP focused on improving the rate of Children aged 2-18 who received the annual preventive dental visit during the measurement Year. BCBS applied a variety of interventions to improve performance for this target population such as the Preventistry Program. The program is a provider-driven intervention established through DentaQuest, the dental vendor for BCBS. The program targets members who have not completed a dental visit in the past 6 to 12 months. The dental providers receive a toolkit containing provider resource information, member handout materials, and a member gap list so they can reach out to members encouraging them to schedule and complete a dental visit. BCBS also conducts call outreach campaigns and post card mailings to this population.

Table 21 – Annual preventive dental visits (children 2-18)

CY 2014	**CY 2015**	**CY2016**
59.18%	61.18%	63.45%

PIP#2 - Long-Term Care: Diabetic Eye Exams: This PIP focused on improving the rate of diabetic LTSS members who received screening for diabetic retinopathy. BCBS continues to identify barriers in order to improve this PIP outcome. BCBS undertook many interventions designed to increase the rates of LTSS members receiving diabetic eye examinations. Some of these interventions included instituting a checklist-based process for notifying nursing facilities and members about potential gaps in care for diabetic members, publishing various member newsletter articles, and explaining the benefits of the Centennial Care Rewards program as it relates to diabetes care which includes regular eye exams. BCBS was able to develop and implement educational training and outreach initiatives to address these deficits, which have made a significant improvement in this area.

Diabetic Eye Exams (LTSS members)		
CY 2014	**CY 2015**	**CY 2016**
8.90%	20.35%	22.76%

PIP#3 - Diabetes Prevention and Enhanced Disease Management: This PIP focused on diabetes management and reducing diabetes short term complications admissions rates. The study population including members admitted to the hospital due to diabetes-related complications. BCBS performance rates reflect fewer hospital admissions due to complications from diabetes from 23.35% in CY 2014 to 17.93% in CY 2016 (lower percentages are better). BCBS interventions aimed at supporting the reduction of hospital admissions related to complications from diabetes include implementing interdepartmental efforts between Quality Improvement and Health Services and Network Services to discuss how to reach members more effectively, and provide outreach to care coordinators and primary care physicians to educate their patients about diabetes care and the benefits and resources available.

Hospital Admissions due to complications from diabetes		
CY 2014	**CY 2015**	**CY 2016**
23.35%	22.16%	17.93%

PIP#4 – Screening and Management for Clinical Depression: This PIP focused on screening for clinical depression and medication management for members 18 to 65+ years of age who were compliant with their antidepressant medications. The PIP was a continuation of the AMQG QIP. BCBS considered CY 2015 the baseline year for screening for clinical depression and CY 2016 for medication management. In collaboration with PRIME Pharmaceuticals, interventions implemented to improve medication compliance included: an antidepressant first-fill patient information letter providing education about antidepressant and medication compliance sent to members who have filled a prescription for an antidepressant for the first time, and the distribution of "The Care Coordinator Quality Handbook", which assists Care Coordinators in engaging members regarding their antidepressant medications.

Screening for Clinical Depression	**CY 2015**	**CY 2016**
18-64 years of age	0.34%	0.43%
65+ years of age	4.14%	2.43%
Medication Management Acute Post-Hospitalization	**CY 2016** **(Baseline year)**	
18-64 years of age	50.63%	
65+ years of age	34.56%	
Medication Management Continuous Post Hospitalization	**CY 2016** **(Baseline year)**	
18-64 year of age	47.17%	
65+ years of age	32.08%	

MHC

PIP#1 – Improvement of Well Child Check Measure: This PIP focused on improving physician documentation for Well Child Care HEDIS measures, body mass index (BMI), counseling for nutrition, and counseling for physical activity. MHC will consider CY 2016 the baseline year for this PIP. Initiatives developed to support this PIP were trainings conducted with providers to improve the rates for the indicators. The trainings included a discussion of the importance of the screening as well as the use of appropriate coding to capture the information.

Improvement of Well Child Check Measures	**CY 2016** **(Baseline year)**
Body Mass Index	7.79%
Counseling for Nutrition	3.82%
Counseling for Physical Activity	2.95%

PIP#2 - Fall Risk Factors and Services Referrals for Long Term Services and Supports: This PIP focused on reducing falls among the LTSS population by providing additional training to care coordinators on fall risk screening. MHC implemented a pilot program for care coordinators in Bernalillo County. The intervention is to provide education to care coordinators that will increase the delivery of fall risk assessment and fall related preventive services to decrease the rate of falls among LTSS members. The training intervention was not implemented until June 2017.

Members with Falls		
CY 2014	**CY 2015**	**CY 2016**
18.47%	24.13%	26.38%

PIP#3 – Diabetes Prevention and Management: This PIP focused on diabetes management, HbA1c testing and reducing diabetes short term complications admissions rates. The PIP was a continuation of the AMQG QIP. Interventions implemented by MHC include service reminders sent to members and their providers about labs, eye exams, and other tests members may have missed or needed, member education on Centennial Rewards for diabetic screening, and education and outreach to members with chronic conditions through the Manage Your Chronic Disease (MyCD) statewide program.

HbA1c Testing		
CY 2014	**CY 2015**	**CY 2016**
18.47%	24.13%	26.38%

Hospital Admissions due to complications from diabetes		
CY 2014	**CY 2015**	**CY 2016**
14.81%	9.75%	11.80%

PIP#4 – Screening and Management of Clinical Depression: The focus of this PIP was to improve the rates of screening for clinical depression and to improve the member's adherence to antidepressant medication for three month and for six months post hospital discharge. The PIP was a continuation of the AMQG QIP. Interventions implemented by MHC included outreach to members newly released from mental health institutions, educating MHC care coordination staff on the importance of engaging with and educating members on attending follow up visits, and referral to MHC peer support program.

Screening for Clinical Depression		
CY 2014	**CY 2015**	**CY 2016**
0.01%	0.06%	0.07%

Antidepressant Medication Management Acute Phase		
CY 2014	**CY 2015**	**CY 2016**
53.50%	49.55%	47.19%

Antidepressant Medication Management Continuation Phase		
CY 2014	**CY 2015**	**CY 2016**
38.63%	34.67%	32.11%

PHP

PIP#1- Services to Children: Annual Dental Visit: This PIP was initiated by PHP to increase annual dental visits in the children. This PIP was introduced in CY 2015 and focused on assessing the effectiveness of the Early and Periodic Screening Diagnostic and Treatment (EPSDT) letters mailed to members and parents to improve the rate of members ages 2-20 receiving an annual dental visit. The study question submitted was, "Will interventions implemented for the identified ADV (annual dental visit) total rate population demonstrate improved rates starting with the rates reported in (HEDIS) 2017?" PHP applied interventions such as placing calls to members to assist with scheduling dental exams. There was a 2.57% point improvement from CY 2015 to CY 2016 in Annual Dental Visits for Children.

Annual Dental Visits Children Ages 2-20	
CY 2015	**CY 2016**
66.43%	69.00%

PIP#2 - Inter-Rater Reliability for Personal Care Services Allocation: This PIP focused on consistent and accurate implementation of the Personal Care Services (PCS) allocation tool by PHP care coordinators. The PIP was introduced in CY 2014 and has increased consistency in the allocation of PCS hours. The intervention consisted of ongoing training and testing for the entire cohort of care coordinators five times during the year. Additionally, as new staff is hired, the training and testing are repeated for the whole group of care coordinators; current and new employees are trained together and then asked to allocate PCS hours based on varying scenarios. The PIP performance has improved 6.7% points from CY 2014 to CY 2016.

Inter-Rater Reliability for Personal Care Services Allocation (LTSS)		
CY 2014	**CY 2015**	**CY 2016**
93.00%	99.40%	99.70%

PIP#3 – Diabetes Prevention and Management: This PIP focused on reducing diabetes short term complications admissions rates and on improving rates of HbA1c testing. The PIP was a continuation of the AMQG QIP. Interventions implemented by PHP to support this PIP included

partnering with practitioners to identify diabetic members with gaps in care, and focused member outreach to assess needs, preferences, and barriers.

HbA1c Testing	
CY 2015	**CY 2016**
84.64%	83.25%

Hospital Admissions due to complications from diabetes (lower is better)	**CY 2015**	**CY 2016**
18-64 years of age	14.56%	11.81%
65+ years of age	37.11%	11.14%

PIP#4 – Screening and Management for Clinical Depression: The focus of this PIP was to improve the rates of screening for clinical depression and to improve the member's adherence to antidepressant medication for three month and for six months post hospital discharge. The PIP was a continuation of the AMQG QIP. Interventions implemented by PHP to support this PIP included a practitioner education campaign via provider newsletters, incentive letters mailed to members who would receive a rewards card upon responding to letter, and member outreach following identification of first prescription fill.

Screening for Clinical Depression	**CY 2015**	**CY 2016**
18-64 years of age	0.14%	0.15%
65+ years of age	0.57%	0.26%
Medication Management Compliant 3 months Post-Hospitalization	**CY 2015**	**CY 2016**
18 years of age and older	53.36%	51.88%
Medication Management Compliant 6 months Post-Hospitalization	**CY 2015**	**CY 2016**
18 years of age and older	36.24%	35.55%

UHC

PIP#1- Annual Pediatric Dental Visits: This PIP was introduced in CY 2014 with a focus on determining the effectiveness of targeted outreach to members and providers on rates of members ages 0 to 20 to get their annual dental exam. UHC identified members in two categories: members less than of 21 years of age who received a preventive dental visit during the measurement year and members less than 21 years of age who received a dental treatment

visit during the measurement year. Interventions included various trainings for care coordinators, dental benefits explanations in EPSDT member information packets, member outreach, and provider education with the goal to remove barriers.

	CY 2014	CY 2015	CY 2016
Preventive Dental Visit less than 21 yrs. of age	28.38%	30.83%	34.04%
Dental Treatment Visit less than 21 yrs. of age	11.74%	11.24%	15.98%

PIP#2- Nursing Facility Transitions: This PIP focused on the effectiveness of a systematic and prescribed program for identification, assessment, and planning for transition and follow-up to increase the number of members who are discharged from in patient nursing facilities and maintained in home or community-based services for at least six months. Interventions implemented in the nursing facility provided a single care coordinator assigned to each facility, whenever possible, to promote development of a working relationship between UHC and the facility. UHC interventions also targeted the education of family members in providing care relevant to the member's needs. Care Coordinators provided education at the time of inquiry into the transition process to increase the understanding of available services and supports within the community setting. Families were encouraged to participate in the member's care in the facility setting to validate their understanding of care needs of the member.

Transitions from Nursing Facility to Community		
CY 2014	CY 2015	CY 2016
1.13%	1.66%	0.83%

Transitions Maintained for at least 180 days		
CY 2014	CY 2015	CY 2016
82.60%	76.90%	There is a 6-month lag time between the member being discharged and the final determination. To cover the entire review timeframe, UHC cannot provide the data until the subsequent year of review.

PIP#3 - Diabetes Prevention and Enhanced Disease Management: This PIP focused on reducing diabetes short term complications admissions rates and on improving rates of HbA1c testing. The PIP was a continuation of the AMQG QIP. UHC actions and interventions included providing professional development opportunities for providers, staff and diabetes educators through the Provider Summits held in Albuquerque and Las Cruces, and "Clinic Days" that were coordinated for members with gaps in care to include all diabetic testing.

HbA1c Testing		
CY 2014	**CY 2015**	**CY 2016**
51.44%	56.32%	60.65%

Hospital Admissions due to complications from diabetes (lower is better)	**CY 2014**	**CY 2015**	**CY 2016**
18-64 years of age (as measured by 100,000 member months)	38.35%	33.42%	37.50%
65+ years of age (as measured by 100,000 member months)	98.80%	270.89%	150.80%

PIP#4 – Screening and Management for Clinical Depression: The focus of this PIP was to improve the rates of screening for clinical depression and to improve the member's adherence to antidepressant medication for three months and for six months post hospital discharge. The PIP was a continuation of the AMQG QIP. UHC actions and interventions implemented to support the PIP included meeting with providers and office staff to discuss depression screening and the capture of data, and working with Care Coordination and Wellness Centers on patient screening and what happened upon a positive screen.

Screening for Clinical Depression		
CY 2014	**CY 2015**	**CY 2016**
929.93	8.20	16.61

Antidepressant Medication Management Acute Phase		
CY 2014	**CY 2015**	**CY 2016**
62.50%	56.62%	53.16%

Antidepressant Medication Management Continuation Phase		
CY 2014	**CY 2015**	**CY 2016**
48.34%	42.89%	38.79%

Outcomes of Performance Measure Monitoring

HSD contracted with HealthInsight as the EQRO to assess the PMs directed by HSD and to assess the MCOs' continuous quality improvement processes for each of the PMs. Below are the questions used by the EQRO to assess performance:

- Did the MCO demonstrate Continuous Quality Improvement processes?
- Did the MCO identify appropriate individuals for interventions and measurement?

- Did the MCO develop and implement effective interventions? and
- Did the MCO appropriately reassess improvement?

The EQRO reviewed and rated each MCO in accordance with the External Quality Review (EQR), Centers for Medicaid and Medicare Services (CMS) Protocol 2 (Validation of Performance Measures Reported by the MCO). Performance rates reported represent members enrolled in Centennial Care during 2016. The MCO performance rates are compared with the average rates reported from the Department of Health and Human Services Region VI for 2016. All 4 MCOs were rated by the EQRO as fully compliant with Centennial Care contractual and regulatory requirements for data tracking processes, quality improvement efforts and performance rate improvements.

For 2016, all of the New Mexico Medicaid MCOs improved or met the Quality Compass regional average or HSD target for: dental visits; controlling high blood pressure; comprehensive diabetes care (retinal eye exams, nephropathy screening, and poor control >9%); timeliness of prenatal care; timeliness of post-partum care; frequency of ongoing prenatal care; and for 7 and 30 day follow up after hospitalization for mental illness.

While the MCOs perform well in most areas, additional attention is needed in the areas of Antidepressant Medication Management and HbA1c testing. Developing and implementing effective interventions to address these issues remains key to improving the health of the Medicaid population. MCOs have worked with providers to have notifications in place to find gaps in care for members who were discharged with short-term complications of diabetes; to address HbA1C testing, retinal eye exams and nephropathy. MCOs have also placed, "tool kits" with educational materials on multiple disease processes with providers to address gaps in care. MCOs are looking to address Antidepressant medication management by collaboration with members in care coordination, as well as identify high-volume antidepressant medication management prescribers. MCOs have identified that the Antidepressant medication management measure has barriers due to claims, and are collaborating with prescribers and pharmacies to better address the claims barriers.

The MCOs showed improvement in a few measures. Follow up after hospitalization - 7 day data showed that each MCO nearly double their previous year's performance. MCOs addressed the previous year's reporting by working with the members as well as facilities to address barriers that the member may face, including transportation as well as providing incentives. Both Prenatal and Postpartum measures also saw a noticeable increase in performance from the previous reporting year due to incentives such as the Baby Benefits rewards program, as well as providing educational material in person and online to promote the benefits of both prenatal and postpartum care. Initiatives such as rewards programs, program material, and continued member and provider education allow for the MCOs to create better relationship with members and providers, and create a positive reflection on performance.

HSD has included seven HEDIS based PMs in the Centennial Care contract for CY 2017 and CY 2018. These PMs will be tracked by the External Quality Review Organization (EQRO) and reported to HSD. The seven PMs with established targets for CY 2017 and CY 2018 include:

- PM 1- Annual Dental Visit
- PM 2- Medication Management for People with Asthma
- PM 3- Controlling High Blood
- PM 4- Comprehensive Diabetes Care
  - Member 18-75yrs of age who had a diagnosis of Diabetes and had an HbA1c test.
  - HbA1c poor control (>9%).
  - Member 18-75yrs of age who had a diagnosis of Diabetes and had a retinal eye exam.
  - Member 18-75yrs of age who had a diagnosis of Diabetes and had a nephropathy screening test or evidence of nephropathy.
- PM 5- Timeliness of Prenatal and Postpartum Care
  - Prenatal visit in the first trimester or within 42 days of enrollment.
  - Postpartum visit on or between 21 and 56 days after delivery.
- PM 6- Antidepressant Medication Management Member 18yrs and older who received at least 84 calendar days of continuous treatment and antidepressant medication (Acute phase).
  - Member 18yrs and older who received at least 180 calendar days of continuous treatment with an antidepressant medication (Continuous phase).
- PM 7- Follow-up after hospitalization for Mental
  - Member 6yrs and older hospitalized for treatment of selected mental health disorders with follow-up within seven calendar days after discharge.
  - Member 6yrs and older hospitalized for treatment of selected mental health disorders and follow-up with a mental health practitioner within 30 calendar days after discharge.

PMs	BCBS 2014	BCBS 2015	BCBS 2016	MHP 2014	MHP 2015	MHP 2016	PHP 2014	PHP 2015	PHP 2016	UHC 2014	UHC 2015	UHC 2016	NCQA Regional Average 2015
Annual Dental visits													
Ages 2-20	57.46	59.63	61.7	62.75	70.07	70.4	68.14	66.43	68.9	41.52	49.88	53.9	**61**
Medication Management for People with Asthma (not a PM in 2014)													
Medication compliance 50%	NA	51.2	55.9	NA	49.3	50.7	NA	54.5	52.9	NA	56.2	64.1	**68** * HSD directed average. National Average not tracked by NCQA
Controlling High Blood Pressure													
Ages 18-85	51.66	56.99	55.6	49.88	51.38	57.7	55.95	56.42	48.4	53.04	49.88	54.25	**44**
Comprehensive Diabetes Care													
Eye Exam	54.23	47.76	51.2	56.51	54.53	59.8	47.75	46.07	51.7	65.21	62.53	60.5	**45**
HbA1c	83.42	80.43	82.5	85.65	88.08	87.1	86.52	84.64	83.2	84.43	84.43	80.5	**83**

testing													
Nephropathy screening	78.61	85.07	87.4	74.83	88.08	89.4	79.53	86.91	87.6	83.70	90.27	91.4	**90**
Poor control HbA1c (>9%)	47.26	52.90	48.5	48.89	45.03	41.0	43.93	48.34	51.7	49.15	52.55	47.9	**60**
Prenatal and postpartum care													
Prenatal care (Timeliness)	73.08	72.61	75.49	76.80	75.97	77.4	77.88	66.36	79.8	63.75	67.40	74.2	**82**
Postpartum visit (Frequency)	54.52	57.91	58.0	54.50	51.49	54.8	61.88	53.13	59.4	48.18	41.63	59.1	**60**
Frequency of ongoing prenatal care													
80% expected visits complete	55.20	50.56	55.8	61.04	55.38	57.4	48.71	42.92	54.8	48.18	34.06	54.9	**61**
Antidepressant medication management													
Acute treatment	59.97	54.8	50.5	53.50	49.55	47.1	53.94	53.36	51.8	62.50	56.62	53.1	**55**
Continuous treatment	47.77	39.40	34.5	38.63	34.67	32.1	38.97	36.24	35.5	48.34	42.89	38.9	**40**
Follow-up after hospitalization for mental illness													
7-days	39.00	34.27	37.21	41.80	34.64	37.50	43.14	32.56	38.35	55.16	54.96	57.94	**46**
30-days	58.49	55.1	58.27	64.80	59.76	63.81	67.88	59.75	62.13	71.00	73.08	74.61	**64**

Summary of Plan Financial Performance

Overview

The Centennial Care contract contains the following financial reconciliations and risk corridors including the contract periods each is effective:

- Retroactive reconciliation (CY14 to current)
- Patient Liability reconciliation (LTSS only – CY14 to current)
- Hepatitis C risk corridor (CY15 to current)
- Other Adult Group risk corridor (CY14 to CY16)

Additionally, the managed care contract includes a provision limiting the MCO's underwriting gain. The underwriting gain limitation is applicable to the non-Other Adult Group populations for CY14 through CY16. Under this provision, MCOs are permitted to retain one hundred percent (100%) of the underwriting gain up to three percent (3%) of net capitation revenue; the MCOs share fifty percent (50%) of any underwriting gain generated in excess of the three percent (3%) with HSD.

Status and Results

In CY17, HSD finalized the financial reconciliations and risk corridor evaluations for the CY14 and CY15 contract period. The results of the financial reconciliations and risk corridor evaluations are reflected in the underwriting gain calculation as either increases or reductions to capitation revenue. For CY14 and CY15 two of the four MCOs exceeded the three percent (3%) underwriting gain limitation and recoupments have been processed for the amount owed to HSD and reflected in the financial results. In CY17, initial evaluations for the CY16 contract period were completed and the final results are scheduled to be completed and processed by the end of CY18.

Since encounter data expenditures are one of the main sources of information used in the reconciliation and risk corridor determinations, HSD continues to work closely with the MCOs to ensure encounters are submitted in a timely and accurate manner. HSD continues to see improvement in encounter submissions.

All MCOs submitted their CY17 fourth quarter financial reports on February 15, 2018. MCOs are required to submit the CY17 annual supplement financial reports on May 15, 2018. HSD monitors MCO contractual compliance for insolvency, reinsurance, and fidelity and performance bond coverage utilizing the financial reports submitted. In the analysis of the financial reporting packages, HSD evaluates the MCOs financial and operational performance at both the individual MCO level and an aggregate level. HSD continues to focus attention on the categorization of expenditures by program, cohort and category of service. Comparison of reported encounter data to financial data also continues to be a main focus in the analysis of financial reports. Financial reporting is another area of continued improvement.

SECTION VI: SUMMARY OF QUALITY OF CARE/HEALTH OUTCOMES FOR AI/AN BENEFICIARIES

During DY4, data indicated that all MCOs showed increases to specialty care visits for psychotherapy, ophthalmology, orthopedic, and cardiology visits for Native American members. All Centennial Care MCOs continued to work on the numbers of HRAs completed in 2017 for Native Americans, some by partnering with tribal organizations to locate members.

Also in DY4, three of the four MCOs saw decreased medical admissions rates for Native Americans. The average length of stay dropped by at least 33% for two MCOs during 2017. The following chart outlines the top 10 Community Benefits utilized during DY4.

Table 22 – Highest Utilized Community Benefit Services by Native Americans

Rank	Procedure Code Description
1	Personal Care (per hour)
2	Environmental Modifications (project)
3	Emergency Response (month)
4	Homemaker (per hour)
5	Respite (per hour)
6	Assisted Living
7	Related Goods
8	Skilled Therapies
9	Private Duty Nursing for Adults-LPN (15 min)
10	Transportation

For BH services in frontier areas, all four MCOs met the access to services targets by 97% or more. For PH services, three of the four MCOs met access to care by 97% or more in frontier areas. In DY4, frequently accessed value added services by Native American members included traditional/alternative healing, full coverage Medicaid for pregnant women, followed by enhanced transportation.

Native American Advisory Meetings

Centennial Care established the Native American Technical Advisory Committee (NATAC), a subcommittee of the Medicaid Advisory Committee, comprised of tribal leaders, and/or appointed tribal representatives, IHS, tribal 638 clinics, and state leadership, to:

- Advise the Medicaid program about how to best serve the tribal communities and Native American Centennial Care members on resolution of issues with MCOs and to facilitate successful reimbursement and reduce administrative burden;
- Address issues related to enrollment, access to care and payment for services and review of program data; and

- Provide updates on the progress of 100% Federal Medical Assistance Percentage (FMAP) for services received through an IHS facility.

The MCOs are also required to conduct individual MCO 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. The MCOs showed an increase in attendance at their NAAB meetings and have extended invitations to tribal leadership, Indian Health Service and community providers.

Table 23 – Schedule of DY4 NAAB Meetings

MCO	Location/Date of Board Meeting	Issues/Recommendations
BCBS	Lovelace Women's Hospital Albuquerque, NM February 23, 2017	Have sound system at meetings. Have info table at entrance to guide people to room. Provide copy of presentation to attendees. Have a traditional healer present.
MHC	Zuni Wellness Center Zuni Pueblo, NM February 22, 2017 Native American Community Academy Albuquerque, NM March 10, 2017	Molina held two Advisory Board meetings this quarter in Tribal programs. Molina uses input from the NAAB meetings to evaluate how well the plan is meeting the needs of its members. The Traditional Medicine Benefit (TMB) is now exclusive to Native Americans age 12 and older and has increased from $100 to $200 dollars per calendar year. Members were encouraged to seek professional help or stay after the meeting to speak to a Molina team member if they were suffering from depression, thoughts of suicide or addiction problems. The Zuni meeting provided translation in the Zuni language. **Issue**: How will changes in the Affordable Care Act affect Medicaid Benefits? **Response**: Molina has served the Medicaid population for 30 years. If there are changes, members will be quickly notified.
PHP	The Cooper Center Albuquerque, NM March 10, 2017	**Issue**: PHP provided clarification that for Native Americans enrolled in their MCO, PHP will automatically assign them to IHS as their primary care provider. **Response**: If the member wants to change to a PCP outside of IHS, they can do so. **Issue**: HME Specialists is the preferred DME vendor for PHP. **Response**: HME will drop off equipment at IHS facilities if the member prefers to pick them up at IHS.
UHC	Mescalero Tribal Office Mescalero, NM March 14, 2017	**Issue**: The MCOs need to be more culturally sensitive on how Tribal members take care of each other in Tribal communities. **Response**: A recommendation is for members to have a companion go with them to their appointments, especially to assist with the language and cultural needs.
BCBS	Hernandez Community Center Hernandez, NM April 26, 2017	BCBS provided an overview of Blue Cross Community Centennial Care including, virtual visits, home and community based services, hypertension and dental education. They also went over the State Behavioral Health survey results.
MHC	San Ildefonso Pueblo Tewa Center San Ildefonso Pueblo, NM May 16, 2017	Members were encouraged to register for MyMolina.com which allows members to manage their health care online. Members were educated on services and benefits offered by MDLive which includes virtual visits, 24/7 online scheduling, and is available after hours and weekends. The members were also presented with two tips for stress relief – deep breathing and muscle relaxation/contraction

MCO	Location/Date of Board Meeting	Issues/Recommendations
		exercises. Members were also informed about the prior authorization process. The Ombudsman educated members about the Ombudsman's roles and responsibilities. Molina members were informed that the cap for the Traditional Medicine Benefit (TMB) has been met and as a result no other application for TMB will be accepted this year. The new funding cycle begins January 1, 2018.
PHP	Alamo Chapter Magdalena, New Mexico May 11, 2017	PHP began their meeting by talking to individuals and families as they entered the meeting room about PHP. PHP decided to do one on one discussions with people while others had food and looked at information. PHP spoke to about 30 people and explained their Native American Affairs program; the difference between FFS and Centennial Care; described their transportation program with Superior Medical Transportation; described the Presbyterian Financial Assistance Program and how it works for individuals who are not insured or underinsured; and explained the Nurse Advice Line, PresRN.
UHC	Eight Northern Pueblos Espanola, New Mexico June 29, 2017	The Native American Advisory Board meeting was held at the Eight Northern Indian Pueblos meeting room. Attendees voiced appreciation for the UHC Tribal Letters Of Agreement (LOA) which allows them to receive payment for the work of their Peer Support teams, translation, health education and health risk assessment (HRA) completion. UHC also described their prior authorization process. Tribes requested a One Stop Shop approach to prior authorizations. UHC will take it back to leadership to discuss.
BCBS	Shiprock Chapter House Shiprock, NM August 24, 2017	BCBS provided an overview of Blue Cross Community Centennial Care and a member advisory board orientation. They explained the importance of attending the Native American Advisory Board meetings. They also discussed what the Alternative Benefits Plan (ABP) is, what it covers and doesn't cover. BCBS talked about the Value Added Services (VAS) they offer, such as the Traditional Healing benefit. The BCBS Ombudsman also was introduced and explained what services he provides for members.
MHC	Mescalero Tribal Building Mescalero, NM August 16, 2017	Members were informed about the following goals: • Explanation of the healthcare systems and benefits; • Engage Members about healthcare initiatives; and • Empower Members to take a proactive role in their care. Members were encouraged to register for MyMolina.com which allows members to manage their health care online. Molina Healthcare uses the input from NAAB meetings to evaluate how well the plan is serving and meeting the needs of its members.
PHP	Santo Domingo Pueblo Santo Domingo Pueblo, NM August 11, 2017	PHP began their meeting by having the Ombudsman for PHP distribute a brochure and information about her role as a member advocate and how to address issues prior to a grievance and appeal. PHP care coordinators also provided a presentation on what the role of a care coordinator is. Audience asked questions, and PHP provided answers to the questions.
UHC	Shiprock Chapter House Shiprock, NM September 12, 2017	The Native American Advisory Board meeting was held at the Shiprock Chapter House on the Navajo reservation. The UHC team discussed the Native American Traditional Healing benefit, prior authorizations for specialty referrals, behavioral health peer support services, and innovations regarding economic development with supporting Tribal CHR programs. UHC recognizes there is a need for UHC providers in Pagosa Springs and Durango, CO for their members living in the northern area of NM. UHC is actively working on getting more providers in this area.

MCO	Location/Date of Board Meeting	Issues/Recommendations
BCBS	Crownpoint Chapter House Crownpoint, NM October 25, 2017	BCBS shared their participation in community events in the Crownpoint area - the employee sponsored fundraisers for school supplies, Kaboom playground equipment, and scholarship/grant programs. All individuals in attendance were new attendees. Navajo translation was provided. BCBS also went over what the Alternative Benefits Plan (ABP) is, what it covers and doesn't cover. BCBS talked about the Value Added Services (VAS) they offer, such as the Traditional Healing benefit. The BCBS Ombudsman was introduced. He explained what services he provides for members. Many audience members had questions which BCBS staff answered during and after the meeting.
MHC	Tribal Administrative Bldg. Acoma Pueblo, NM November 3, 2017	Molina members were informed of the purpose for Native American Advisory Board (NAAB) meetings, which included an opportunity for members to provide feedback. The feedback received from today's meeting will be shared with the Member and Provider Satisfaction Committee (MPSC). MPSC is comprised of various Molina departments to develop action plans when barriers are identified in the member's community as well as opportunities for improvement. There were questions about personal care services and transportation at the meeting. Molina answered the questions and referred members to the ombudsman as needed.
PHP	Mescalero Tribal Offices Mescalero, NM October 13, 2017	Presbyterian stated the purpose of the NAAB meetings is to get feedback from their Centennial Care members. PHP told their audience that if they need referrals to see specialists outside of IHS, PHP can help with this as well as the transportation piece if needed. Several individuals in the audience asked how members can get home modifications, grab bars, a ramp, etc. PHP explained that the care coordinator will need to come in and do an assessment. Other questions were answered during the meeting or after the meeting.
UHC	Hilton Garden Inn Gallup, NM December 1, 2017	The UHC team discussed the UHC benefits for Native Americans and how to get prior authorizations for specialty referrals. They also informed members where to go to resolve billing issues if they come up. The attendees did not have questions for further discussion.

Update on Enhanced FMAP for Services Received Through an IHS Facility:
In DY4, there were two signed Care Coordination Agreements (CCAs): 1.) The University of New Mexico Hospital (UNMH) and Presbyterian Healthcare Services; and 2.) UNMH and Albuquerque Area Indian Health Service (AAIHS).

The IT and clinical teams for AAIHS and UNMH meet monthly to review and test the processes for services received through an IHS Facility. UNMH developed a flow chart that describes each of the steps in the process. HSD provided UNMH with a provider file which contains a list of AAIHS provider names, domain, NPI numbers, and the direct domain address of the clinicians. This information will be updated on a monthly basis and HSD will provide the file to UNMH. Billing for these services will begin in April 2018.

The PHS and AAIHS agreement was signed late in DY4 and will require additional collaboration in DY5 prior to full implementation. Presbyterian will be working with AAIHS Information Technology Division to ensure the two systems can share information on referrals and follow up

as well as share medical records. Presbyterian will also receive the AAIHS provider file monthly from HSD.

Formal Tribal Consultations in DY4

HSD held two formal Tribal consultations during DY4: One was held June 23, 2017 regarding the Centennial Care 2.0 Concept Paper with eight Tribal leaders or their designee in attendance; and a second formal Tribal consultation was held on October 20, 2017 regarding the Centennial Care 2.0 Draft Application for the renewal of the Section 1115 Demonstration Waiver with six Tribal leaders or their designee in attendance. Input from Tribal Leaders on the 1115 Waiver Renewal is included in Attachment F: Public Comments Summary and Response.

SECTION VII: QUALITY STRATEGY/HCBS ASSURANCES

Quality Strategy

HSD received approval for the Quality Strategy from CMS in May 2014. The Quality Strategy was reassessed and revised in September 2017 to report the program outcomes through calendar year 2016. New Mexico will continue to assess quality outcomes to determine the need for modification to the Quality Strategy.

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

Several quality initiatives and monitoring of State standards support the commitment to provide access, quality and appropriateness of care to the States Medicaid Beneficiaries. These ongoing activities, discussed throughout this report include continuous monitoring of State established Standards including; Quality Management and Quality Improvement Standards (QM/QI); Utilization Management Standards; MCO Accreditation Standards; Care Coordination Standards; Access and Network Adequacy Standards, Provider Standards; Transition of Care Standards; and Monitoring and Reporting Standards. Many of the quality strategy activities have been previously explained in other sections of this report.

- Please refer to Section II for information related to Quality Assurance, Access and Network Adequacy, Care Coordination, and Adverse Incidents Monitoring.
- Please refer to Section V for information on activities related to Utilization Management, Performance Measure Monitoring, Performance Improvement Projects, and Member Satisfaction.

HCBS Assurances

HSD uses the CMS approved Centennial Care Quality Strategy to monitor the HCBS assurances. There are four areas identified in the quality strategy.

Level of Care (LOC) Determinations

HSD continues to conduct 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.

EQRO Compliance Audit

HSD contracts with HealthInsight to conduct the External Quality Review (EQRO) for compliance with State Standards. During DY4, the EQRO completed the compliance review for CY 2016 HCBS areas including; Self-Directed Community Benefits, Care Coordination, and Transition of Care from the Nursing Facility to Community. The review process is designed to assess compliance of the MCO policies, procedures, activities and outputs with the contractual obligations.

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 three report on adverse incidents.

SECTION VIII: STATE CONTACTS

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SECTION IX: ENCLOSURES/ATTACHMENTS

Attachment A: Annual Budget Neutrality Monitoring Spreadsheet
Attachment B: 2017 Value Added Services
Attachment C: 2017 NM Consumer and Family Executive Summary
Attachment D: 2016-17 GeoAccess PH All MCOs
Attachment E: 2017 BH GeoAccess BH Summary All MCOs
Attachment F: Public Comments Summary and Response
Attachment G: Key Utilization/Cost per Unit by Major Population Group