Centennial Care Waiver Demonstration

Section 1115 Annual Report
Demonstration Year: 3 (1/1/2016 – 12/31/2016)

March 31, 2017

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 694,000 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.

As a beginning place for 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 (BCBSNM)
- Molina Healthcare of New Mexico (MHNM)
- Presbyterian Health Plan (PHP)
- United Healthcare (UHC)

SECTION II: SUMMARY OF QUARTERLY REPORT OPERATIONAL ISSUES

Annual Budget Neutrality Monitoring Spreadsheet

The annual budget neutrality monitoring spreadsheet for demonstration year three (DY3) is included in this report as Attachment A.

Health Care Delivery System Update

Benefits

There were no changes in Medicaid covered services or benefits during DY3. In addition to Medicaid covered services, the MCOs are permitted to provide value added services (VAS) to their members, which must be approved by the Human Services Department (HSD). Value Added Services are additional services covered by the MCOs which may fall within any of the Centennial Care program services areas, physical health, behavioral health and/or long term services and supports. MCOs may also offer VAS to members who receive the alternative benefit plan (ABP). Services vary by MCO and are outlined in Attachment B and C – Value Added Services 2016 and 2017.

Behavioral Health

For an update on DY3 Behavioral Health Initiatives, please see Attachment D – Behavioral Health Collaborative CEO Report.

New Mexico Behavioral Health Consumer Satisfaction Survey

HSD conducts an annual consumer, family/caregiver, and youth satisfaction survey for Centennial Care members with identified BH needs. This is a joint effort between CYFD, HSD, and the four MCOs. The results are used to identify areas for service improvement.

The survey reports on domains that are then able to be compared with national data. The domains are:

- Access
- Participation in Treatment
- Improved Functioning
- Social Connectedness
- Outcomes
- Quality and Appropriateness
- Cultural Sensitivity
- Overall Satisfaction

Please see Attachment E – 2016 Consumer Satisfaction Survey Report, for more information and findings from DY3.

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 III of this report. There were some slight decreases in SSI and Related, both Medicaid Only and Dual but all other groups increased. Overall enrollment continues to increase each quarter in almost every population.

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. There is a slight increase in disenrollment but only in certain populations and is tied to the overall increase in enrollment.

Complaints and Grievances
In DY3 a total of 3,787 member grievances were filed by Centennial Care members; a 14% decline from DY2 with 4,385 member grievances. During 2016 there were 888 member grievances received in Q4, 871 received in Q3, 934 in Q2 and 1,094 received in Q1.

In DY3 the top member grievance type filed was Non-Emergency Ground Transportation (NMET) with 919 of the total grievances received; a 26% decline from DY2 with 1,241 NMET grievances. The MCOs continue to meet regularly with their transportation vendors and have initiated process improvement initiatives or performance plans to address the identified issues such as "no shows" and rescheduling appointments if necessary. For DY4, HSD has revised the MCO complaints and grievances report with the objective to include additional information regarding process improvement initiatives and outcomes.

In DY3 the second top member grievance type filed was Other Specialties, with 514 received; a 71% increase from DY2 with 301 member grievances. Balance billing, the practice of billing the member for a remaining balance, was the outstanding trend for 2016. The MCOs address this issue on a case by case basis and provide education to the provider.

The third top member grievance filed was Primary Care Physician (PCP) with 410; a 4% decline from DY2 with 428 member grievances. Reported grievances identify long wait times and unprofessionalism of the PCP and/or the PCP's staff, as well as dissatisfaction with the PCP for not filling requested prescriptions. The MCOs perform outreach and education to the provider on a case by case basis.

In DY3 the remaining 1,944 are noted, but not enough information is found to establish a trend. Grievances include complaints about dental and vision services, quality of care, and durable medical equipment. 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 DY3

MCO Grievances DY3 2016										
MCO	BCBS		MOLINA		PHP		UHC		**Total**	
Members Grievances	#	%	#	%	#	%	#	%	#	%
Total Number of Member Grievances Filed During Reporting Period	422	11.14%	931	24.58%	1208	31.90%	1226	32.37%	3787	100.00%
Transportation Ground Non-emergency	275	7.26%	167	4.41%	189	4.99%	288	7.60%	919	24.26%
Other Specialties	33	87.00%	6	0.16%	124	3.27%	351	9.27%	514	13.57%
Primary Care Physician (PCP)	12	0.32%	103	2.72%	246	6.50%	49	1.29%	410	10.83%
Grievances Pending	102	2.69%	655	17.30%	649	17.14%	538	14.21%	1944	51.34%

Member Appeals

In In DY3 a total of 5,104 appeals were filed by Centennial Care members; a 6.09% decrease from DY2 with 5,435 member appeals received. MCOs reported the highest reason for member appeals were due to denial or limited authorization of a requested service and the second highest reason for member appeals was a reduction of a previously authorized service. During 2016 there were 1,476 member appeals received in Q4, 1,143 received in Q3, 1,264 received in Q2 and 1,221 received in Q1. Of the total appeals filed 3,021 were upheld, 36 were partially overturned and 1,440 were overturned. There were 607 appeals that were transitioned into Fair Hearings or were still pending resolution at the end of the year.

Table 2 – MCO Appeals DY3

MCO Appeals DY3 2016										
Members Appeals	Q1		Q2		Q3		Q4		Total	
	#	%	#	%	#	%	#	%	#	%
Total Number of Member Appeals	1221	23.92%	1264	24.76%	1143	22.39%	1476	28.91%	5104	99.98%
Total Number of Appeals Upheld	790	64.70%	835	66.06%	731	63.95%	665	45.05%	3021	59.18%
Total Number of Appeals Partially	7	0.57%	9	0.71%	14	1.22%	6	0.40%	36	0.70%
Total Number of Appeals Overturned	378	30.95%	391	30.93%	374	32.72%	297	20.12%	1440	11.89%

Access

Throughout this report, unless otherwise noted, the most current monthly data available is through February 2017. Quarterly data is available through the third quarter of 2016.

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. New Mexico also recognizes providers/pharmacies within 100 miles of the border as in-state providers. In July 2016, HSD initiated provider rate reductions; however, all of the MCOs reported their respective provider networks remained stable and rate reductions did not result in provider terminations during DY3. In addition, all MCOs were far below the primary care provider (PCP)-to-member contractually required ratio of 1:2000 in DY3. The ratios ranged from 1:21 to 1:101 as reported by the MCOs in the third quarter. There were not any identified PCP ratio concerns in 2016. 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	Sept
BCBS	1:56	1:56	1:54	1:55	1:56	1:56	1:40	1:40	1:42
MHC	1:111	1:111	1:111	1:108	1:107	1:105	1:101	1:101	1:101
UHC	1:17	1:17	1:17	1:16	1:16	1:16	1:18	1:16	1:21
PHP	1:83	1:85	1:87	1:88	1:89	1:89	1:87	1:87	1:87

Source: [MCO] PCP Report #53, Q3CY16

During DY3, GeoAccess reports were reviewed by HSD to ensure consistent methodology across MCOs. HSD identified discrepancies in MCOs' reporting. The discrepancies included duplication of provider locations, and the inability to accurately calculate physical location of provider. HSD examined the methodology and the ability within the MCOs' software packages to choose point-to-point distance measurements or the mileage traveled to the nearest provider. In addition, to ensure consistent methodologies among MCOs, HSD conducted technical assistance (TA) calls with each MCO to ensure accurate reporting of provider locational counts and the physical location of the provider. All MCOs changed their methodology to use miles traveled rather than point to point.

Geographic access requirements for hospitals, primary care physicians, pharmacies, dentists and most specialty providers were met in urban, rural and frontier counties. A shortage of providers continues for all MCOs in specialty areas including dermatology, endocrinology, neurosurgeons, and rheumatology. Please see Attachment F – GeoAccess PH Summary. 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.

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. While MCO GeoAccess Reports measure proximity of members to providers and Network Adequacy Reports measure capacity by MCO, HSD conducted a Secret Shopper Survey in DY3 to determine whether the overall Medicaid network of providers is able to offer timely appointments to its managed care members across MCOs.

HSD created a script and provided instruction for staff to conduct the survey. The survey was designed to measure time to a new patient appointment, time to an established patient appointment, and time to obtain a sick/urgent patient appointment along with other data points. The additional data included, but was not limited to: whether the practice accepts Medicaid as a payor, whether the practice accepts new patients, the availability for extended hours, and the MCOs with which the practice was contracted. The script was designed to be conversational and to not require specific member information. See Attachment G – NM HSD Secret Shopper Survey script.

HSD selected primary care physicians and three specialty care provider types from the State's Medicaid Management Information System (MMIS). Providers from the specialty areas of Cardiology, Obstetrics and Gynecology, and Pediatrics were selected. See Attachment H – NM HSD Secret Shopper Survey Methodology.

HSD/MAD staff members were trained and coached to ensure consistency and reliability across surveyors. One-to-two attempts were made to reach each provider or practice during the survey period.

Except for new patient Cardiology appointments, the time-to-appointment standards were met or were offered earlier than the contract requirements in the Medicaid Managed Care Services Agreement. Additional information included:

- 13% of PCPs offered extended hours (evening and/or weekend hours);
- 93% of PCPs who were reached accepted Medicaid, and of those providers, 88% were contracted with all four MCOs;
- Only 2% of providers referred members to Urgent Care or an Emergency Room when asked how soon an established patient could be seen for a sick or urgent appointment; and,
- On average, established patients, who identified as sick or needing an urgent appointment, could be seen within 1 business day. On average, pediatricians could see established members, whose parent reported similar conditions, either the same day or within 1 business day. See Figures 1–4 below.

By selecting a random sample of PCP providers, HSD was able to stratify the results by geographic area (urban, rural and frontier) for which the stratum in the sample was determined to be in proportion to the defined population, or "universe" of providers. As noted in HSD's methodology, one hundred percent of specialty providers were surveyed. While time-to-appointment standards are not differentiated in the Medicaid Managed Care Service Agreement by geographic area, HSD was able to determine whether geographic area impacted time-to-appointment for members. Remarkably, time-to-appointment, in some instances, was quicker in frontier areas than in urban areas where more providers are available.

In two instances, specialty area providers were not available in frontier areas, and while members have access to providers using non-emergent transportation services, telemedicine and single case agreements, the results were not consistent with MCO access and network adequacy reports. HSD was able to determine that the reason for the discrepancies is explained by the absence of "border area" providers in the data definition for the provider universe. Border area providers are providers within 100 miles of the State's U.S. border and are considered to be "In-State" for purposes of the New Mexico provider network. Going forward, HSD will include border area

providers in surveys to provide a more complete snapshot of time-to-appointment access for members in border areas which are all either rural or frontier.

An additional process change will be to increase the number of attempts to reach providers/ practices from one-to-two times to a standard three attempts at different times of the day. The percent of providers reached for this survey ranged from 80-to-100% as noted in Figures 1 – 4.

Figure 1. Time-to-Appointment: PCPs

PCPs			
80% of practices were reached of which 87% are accepting new patients. 93% accept Medicaid & of those 88% are contracted with all 4 MCOs.			
Average time to:	**New Pt. Appt.**	**Est. Pt. Appt.**	**Sick/Urgent**
ALL	2 weeks	3-4 days	1 day *
URBAN	2 weeks	3-4 days	Same day-1 day
RURAL	2 weeks	4 days	1-2 days
FRONTIER	1 week	3 days	Same day
n = 196			
* *2% of providers said to go to an Urgent Care or Emergency Room.*			
13% of PCPs offer extended hours (evening or weekend hours or both)			

Figure 2. Time-to-Appointment: Cardiologists

Cardiologists			
100% of practices were reached of which 93% are accepting new patients. 79% accept Medicaid & of those 100% are contracted with all 4 MCOs.			
Average to:	**New Pt. Appt.**	**Est. Pt. Appt.**	**Sick/Urgent**
ALL	7 weeks	3-7 days	Same day
URBAN	7 weeks	6-11 days	Same day
RURAL	7 weeks	1-3 days	Same day
FRONTIER	--	--	--

Figure 3. Time-to-Appointment: Pediatricians

Pediatricians			
91% of practices were reached of which 98% are accepting new patients. 100% accept Medicaid & of those 100% are contracted with all 4 MCOs.			
Average to:	**New Pt. Appt.**	**Est. Pt. Appt.**	**Sick/Urgent**
ALL	1 week	2-4 days	Same day-1 day
URBAN	1 week	2-5 days	Same day
RURAL	1 week	1-3 days	Same day-1 day
FRONTIER	1 week	1-2 days	1-2 days

Figure 4. Time-to-Appointment: OB-GYNs

OB-GYNs			
81% of practices were reached of which 90% are accepting new patients. 90% accept Medicaid & of those 77% are contracted with all 4 MCOs.			
Average to:	**New Pt. Appt.**	**Est. Pt. Appt.**	**Sick/Urgent**
ALL	3 weeks	5 days	Same day-1 day
URBAN	3 weeks	5 days	Same day-1 day
RURAL	3 weeks	5 days	Same day-1 day
FRONTIER	--	--	--

Telemedicine

All MCOs continued to expand telemedicine services for both PH and BH in DY3. All MCOs have active recruitment initiatives underway to pursue contracting with telemedicine providers. MCOs also incentivized the use of telemedicine with the acquisition of audio-visual equipment for several practice sites, so they can start to provide telemedicine services to their patients. Additionally, MCOs provided training for correct coding to providers to ensure utilization is properly captured. All MCOs strive to meet the goal of increasing member utilization by 15% over DY2 goals. DY3 utilization results indicate a 55% increase compared to DY2 utilization results of 47% for a total of a 17% increase. Please see Table 4: Telemedicine 2013 - 2016 Results.

Table 4 – Telemedicine 2013 - 2016 Results

	Baseline			1st Year Results			2nd Year Results			3rd 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
BCBS	19	3	22	1,078	91	1,169	1,213	803	2,016	2,362	2,803	5,165
MHNM	7 *	0	7	1,909	32	1,941	2,132	754	2,886	3,579	98	3,677
PHP	2,016	4	2,020	3,006	143	3,149	3,809	134	3,943	5,045	280	5,325
UHC	89	22	111	1,046	96	1,142	1,833	236	2,069	1,786	1,000	2,786
TOTAL	2,131	29	2,160	7,039	362	7,401	8,987	1,927	10,914	12,772	4,181	16,953

* 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] 2016 DSIPT Results Reporting

Transportation

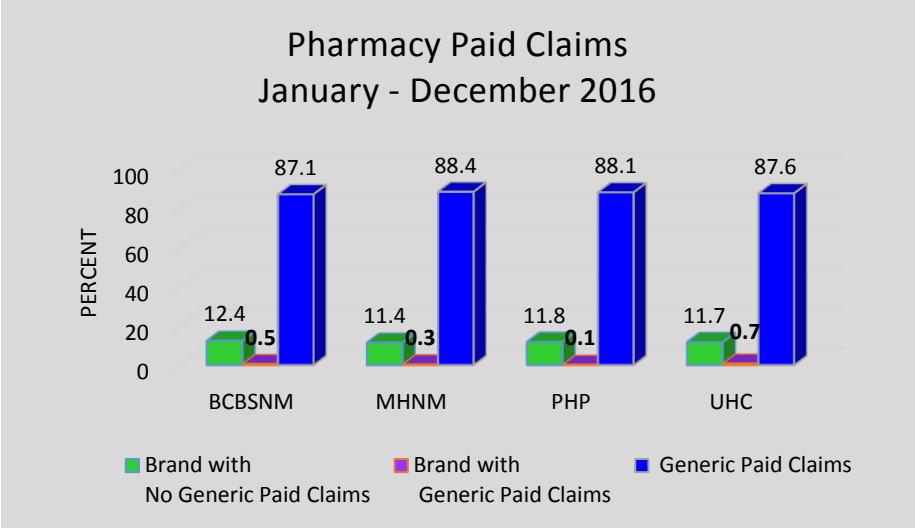
In DY3, all MCOs met geographic access standards for non-emergent ground transportation in urban, rural and frontier areas.

Pharmacy

During DY3, the HSD pharmacy reports workgroup determined the additional adjustments needed to standardize a consistent methodology across the MCOs including CMS required elements for Drug Utilization Review (DUR) reporting. The standardization include the 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. MCOs will continue to report the following data elements: the total number of claims submitted; paid claims for unduplicated members; prior authorization requirements; and therapeutic classifications to be based on "Generic Product Indicators" to prevent the reporting of high numbers of miscellaneous items. These revisions will reduce variances in reporting among MCOs; ensure a thorough analysis of pharmacy services; ensure prescriptions are appropriate, medically necessary, and not likely to result in adverse medical issues.

HSD also monitors MCO's utilization of generic medications. 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. MCOs continue to report high generic drug utilization with an 87.8% average for all four MCOs, brand with no generic available is at an average of 11.8% for all MCOs and brand use with a generic drug available is at a 0.4% average. HSD has not identified any concerns at this time and will continue to monitor utilization of generic drug utilization and brand name drug utilization. See Table 5: Pharmacy Paid Claims, January – December 2016

Table 5 – Pharmacy Paid Claims, January – December 2016



Source: [MCO] Report #44, December 2016

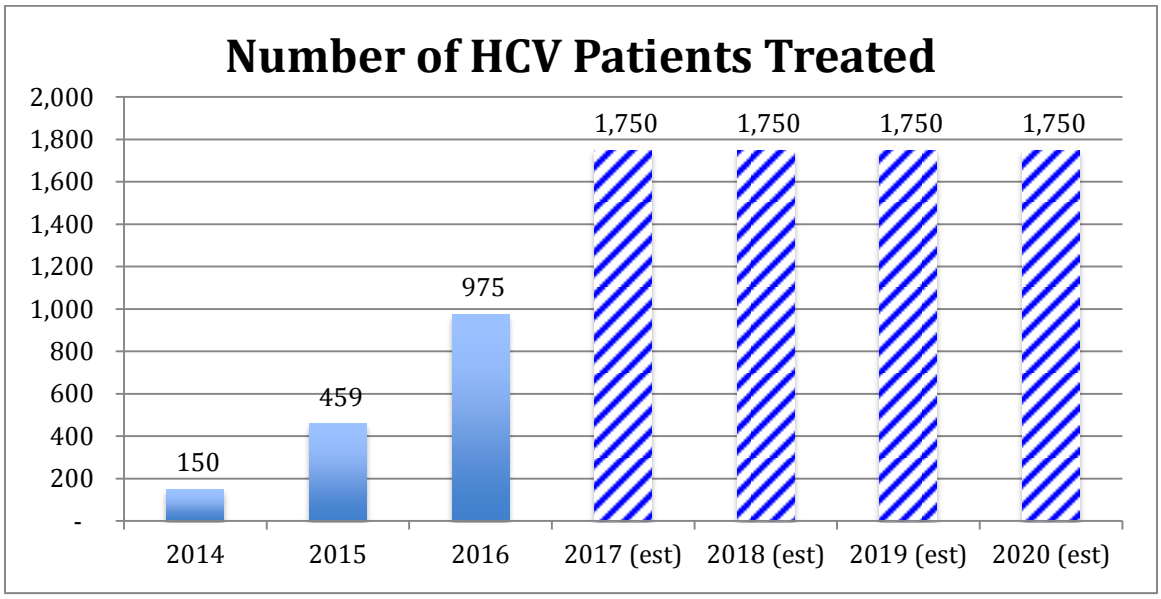
Hepatitis C

In late 2015 the Medical Assistance Division issued a Letter of Direction to the MCOs in order to clearly define expectations from our contractors related to treatment of Hepatitis C (HCV). This letter provided rigorous definitions for which Centennial Care members with active HCV infection should be treated (F2, F3, F4, decompensated cirrhosis, and hepatocellular carcinoma), and also expanded the role of care coordination for these patients. In addition, the MCOs were given specific instructions for expanding case finding through screening programs, and the requirement for only certain specialists to treat was eliminated.

There also was a change to financial incentives for the MCOs. A new element in the Delivery System Improvement Fund was established to encourage MCOs to meet treatment targets for HCV. Designed to be phased in over two years, the MCOs were required to meet 50 percent of their member-month adjusted target in 2016, and 75 percent in 2017,

The table below illustrates the results of the expanded benefit plan, enhanced accountability of the MCOs, and the modified incentives for 2014 to 2016:

Table 6 – Number of HCV Patients Treated



The number of members treated in 2016 was more than twice the number treated in 2015, which is a remarkable improvement.

MAD met with the MCOs on a quarterly basis in 2016 to enhance the number of members treated for active HCV infection. In collaboration with a New Mexico expert in the treatment of HCV, Karla Thornton, MD, the group addressed issues related to screening, case finding, provider training, collaboration with Project ECHO, and many other issues. In the fourth quarter of 2016, MAD worked with the MCOs to develop 2017 treatment guidelines and an expanded benefit program.

The MCOs and MAD together identified the following key barriers to identifying and treating more members in 2016:

1) The largest cohort of HCV positive individuals are in the Medicaid Expansion group. Due to their prior uninsured status, this cohort has the highest prevalence of active HCV infection. In addition, NHANES and other data sources suggest that this cohort has a much lower awareness of their own Hepatitis C status. As few as 25 percent of this population may be aware they have active infection. The combination of a higher incidence and a lower awareness in this population represents a unique challenge to our state.
2) Despite the fact that we are making a transition from a specialty-only treatment network to add primary care physicians, we do not have an adequate number of trained treating providers to ensure that all HCV positive individuals are identified and treated.
3) New Mexico is a largely rural state, with a number of "frontier" counties, making robust screening efforts more challenging.

Currently, a new MAD-MCO workgroup is addressing the three challenges outlined above and will spend 2017 reaching out to providers to better understand how we can train more of them to treat more of our members.

In late 2016, MAD expanded its HCV treatment benefit to now include F1 patients. This new plan became effective January 1, 2017.

Community Interveners (CI)

In DY3, there were seven Centennial Care members who received CI services. The MCOs continued to provide training and education to care coordinators to identify potential members who could benefit from CI services.

HSD approved another provider to provide CI services, All 4 You Home Care Corp. Two MCOs have contracted with All 4 You Home Care Corp. This new provider will assist with identifying members who may qualify for the CI services.

Table 7 – Consumers and Community Intervener Utilization

MCO	# of Members Receiving CI	Total # of CI Hours Provided	Claims Billed Amount
BCBSNM	3	2430	$15,613.25
MHNM	0	0	$0.00
UHC	3	1129	$7,291.50
PHP	1	91	$556.25
Total	**7**	3650	**$23,461.00**

Unreachable Member Campaign

Care Coordination is the cornerstone for Centennial Care and achieving a comprehensive system of care. Care Coordination activities facilitate the "right amount of care at the right time and in the right setting" as well as increasing cost efficiencies. As reported in DY1, when the MCOs reported unexpected challenges in locating and engaging all of their members within the first six months of the program, HSD directed all four Centennial Care MCOs to initiate unique and innovative campaigns to connect with their "unreachable members." The goal was to achieve a minimum decrease of ten percent by October 1, 2014, and a five percent reduction each month thereafter. The Unreachable Member Campaign concluded in DY3 with monthly goals having been reached. The results are reported in Attachment I – Figure 1. Unreachable Member Campaign Progress Report.

Each MCO had fluctuations in performance as it initiated and refined its strategies and processes to reach members. Attachment J – Figure 2. Unreachable Member Campaign Performance Tracking represents the combined efforts of the MCOs for an overview of campaign results at the program level. Some of the quantitative program results are as follows:

248,513 previously determined "unreachable" members were successfully reached during the campaign.

The percent of unreachable members, as compared to enrollment, decreased to 11.6%.

164,267 total HRAs were completed for members who had initially been unreachable.

From January 2015 through June 2016, the number of members reached can be compared to the HRAs completed for a penetration rate of 73.3%.

As seen in the Performance Tracking graph, there were significant gains in the first six months of the initiative. This was followed by upticks in July 2015 and February 2016 as progress began to level off. MCOs report that the eventual leveling off was due to the population of unreachable members becoming concentrated with members who are the most difficult to locate. As one of the MCOs noted, the threshold of diminishing returns occurred when the organization reached approximately 20% of unreachable members compared to enrollment.

Beginning July 1, 2016, HSD eliminated the requirement for an annual re-assessment healthier members; those who are not in higher levels of care (Care Coordination Levels 2 and 3). Rather, MCOs are required to conduct an initial HRA for members newly enrolled in Centennial Care and a new HRA for members who are identified as having a change in health status. A member can also self-report a change in health status, and the MCO will complete a new HRA to determine the member's appropriate level of care.

Going forward, MCOs will focus on assessing utilization and claims data, including Emergency Room visits, services and supports history, medications and medication history in order to identify a member's current and emergent needs related to Care Coordination. For those members who are determined to belong in higher levels of care, HSD has shifted its focus for monitoring Care Coordination from unduplicated members reached to the percent of timely touchpoints and assessments to determine members' needs.

Care Coordination continues to be an essential component of the Centennial Care program by anticipating members' needs rather than responding to emergencies or exacerbated health conditions.

Emergency Department Information Exchange

The Emergency Department Information Exchange (EDIE) is an MCO collaborative effort utilized to promote appropriate utilization. In July 2016, implementation of the EDIE project was launched. EDIE allows the MCOs to increase the impact of their existing care coordination resources by automatically aggregating a full census of all Emergency Department (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 meta data. 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. Furthermore, it is anticipated that EDIE will reduce non-emergent visits, so the ED providers have the capacity to rapidly see those with emergent needs as well as reduce the associated costs due to unnecessary ED visits. Additionally, all MCOs continue contracting efforts with hospitals in order to successfully implement the EDIE project to track utilization, with the collaborative support between CHWs and care coordination teams for inpatient or recently discharged members.

Long-Term Services and Supports

Long-Term Care (LTC) Workgroup

In DY3, HSD created a Long-Term Care (LTC) workgroup that includes representatives from the MCOs. The LTC workgroup had many accomplishments in DY3 including but not limited to:

- Implementation of the Community Benefit Services Questionnaire (CBSQ). The CBSQ is used by the care coordinator during the comprehensive needs assessment (CNA) to ensure members are informed of all available Community Benefit (CB) services;
- Development of a CB brochure to provide members and their families about the vast array of CBs available;
- HSD implemented ride-alongs with the MCOs' care coordinators to monitor the MCOs' implementation of the CBSQ and brochure. The ride-alongs have been beneficial for both HSD and the MCOs as feedback is provided to the MCOs after the visit;
- Collaboration on the implementation of the CMS Final Rule;
- Collaboration on contract amendment language and policy manual language regarding long term services and supports;
- Implementation of a project that focused on the alignment of MCOs for dually eligible members; and
- Collaboration on the development of trainings for MCO staff.

In DY3, HSD issued two letters of direction (LODs) to the MCOs to clarify timelines and processes for sending the Nursing Facility Level of Care (NF LOC) SOC through the system interfaces. HSD also conducted training on the LODs for the MCOs' program and systems staff in March and September 2016. In DY3, HSD continued to develop and seek CMS approval for the New Mexico Home and Community Based Services (HCBS) State-Wide Transition Plan as required by the CMS HCBS Settings Final Rule.

Electronic Visit Verification (EVV)

Although many NM personal care services (PCS) providers, particularly in urban areas, have already been using the EVV system, in November 2016, HSD required all PCS providers to use the system. Caregivers have three options for tracking their time:

1. Use the member's landline with the member's permission
2. Use the Authenticare application through the caregiver's smartphone. MCOs reimburse the caregiver with a small monthly stipend to cover data usage costs.
3. Use the Authenticare application through a tablet that is provided by the MCO. Rural caregivers must come into a connectivity area every seven days (Verizon network or Wi-Fi) for the application data to upload.

HSD will continue to monitor the use of the EVV system through reporting and collaboration with the MCOs and providers.

Other Operational Issues

Contract Amendments

There were two amendments to the Centennial Care MCO contracts in DY3, Amendments #5 and #6. MCO contracts and amendments can 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 DY3, 17,095 critical incidents were filed for Centennial Care, Behavioral Health and Self-Directed members. Of the 17,095 reports filed, 4,000 reports were submitted in Q4; 4,368 in Q3; 4,220 in Q2; and 4,507 in Q1. MCOs reported data entry errors and timely filing as barriers to accurate and timely submission. Data entry errors include incorrect categories of eligibility, incomplete or inaccurate information. Timely filing includes delays in reporting information and, delays between agency knowledge and report filing. MCOs have a multi-level educational process with internal and external collaborators to reduce inaccurate and un-timely submissions.

During DY3, a total of 1,698 deaths were reported. This is an increase from 1,433 from DY2. Of the 1,698 deaths reported, 1,540 deaths were reported as natural, expected deaths, 148 deaths were reported as unexpected and ten 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 DY3, Centennial Care, Behavioral Health and Self Directed populations reported a total of 10,931 (64%) critical incidents for Emergency Services. Of those Emergency Services reports, 1,221 were Behavioral Health and 452 were Self-Directed. MCOs collaborate on internal and external initiatives. HSD will continue to monitor any decreases or increases of emergency services reports.

Table 8 – Critical Incident Types by Population Group

Critical Incident Types by Population Group								
Critical Incident Types	Centennial Care		Behavioral		Self Directed		Total	
	#	%	#	%	#	%	#	%
Abuse	727	4%	420	2%	78	0%	1,225	7%
Death	{1534}	9%	{106}	1%	{58}	0%	{1698}	10%
Natural/Expected	1394	8%	90	1%	56	0%	1,540	9%
Unexpected	130	1%	16	0%	2	0%	148	1%
Suicide	10	0%	0	0%	0	0%	10	1%
Elopement/Missing	77	0%	48	0%	1	0%	126	0%
Emergency Services	9258	54%	1,221	7%	452	3%	10,931	64%
Environmental Hazard	264	2%	19	0%	5	0%	288	2%
Exploitation	408	2%	36	0%	37	0%	481	3%
Law Enforcement	330	2%	93	1%	18	0%	441	3%
Neglect	1729	10%	140	1%	36	0%	1,905	11%
Total	14327		2083		685		17095	

Table 9 – Critical Incident Types by MCO

Critical Incident Types by MCO - Centennial Care								
Critical Incident Types	BCBS		Molina		Presbyterian		UHC	
	#	%	#	%	#	%	#	%
Abuse	161	5%	401	7%	319	12%	344	6%
Death	445	14%	485	8%	276	10%	492	9%
Elopement/Missing	9	0%	44	1%	34	1%	39	1%
Emergency Services	2,046	63%	4,143	72%	1,443	53%	3,299	61%
Environmental Hazard	35	1%	64	1%	85	3%	104	2%
Exploitation	85	3%	122	2%	83	3%	190	4%
Law Enforcement	82	3%	144	2%	95	4%	121	2%
Neglect	384	12%	365	6%	365	13%	791	15%
Total	3247		5,768		2,700		5,380	

Table 10 – Critical Incident Types by MCO – Behavioral Health

Critical Incident Types by MCO - Behavioral Health								
Critical Incident Types	BCBS		Molina		Presbyterian		UHC	
	#	%	#	%	#	%	#	%
Abuse	31	26%	218	15%	151	41%	20	15%
Death	5	4%	85	6%	9	2%	7	5%
Elopement/Missing	0	0%	26	2%	18	5%	4	3%
Emergency Services	55	47%	978	67%	114	31%	74	56%
Environmental Hazard	0	0%	9	1%	9	2%	1	1%
Exploitation	3	3%	22	2%	6	2%	5	4%
Law Enforcement	14	12%	42	3%	26	7%	11	8%
Neglect	10	8%	85	6%	35	10%	10	8%
Total	118		1,465		368		132	

Table 11 – Critical Incident Types by MCO – Self Directed

Critical Incident Types by MCO - Self Directed								
Critical Incident Types	BCBS		Molina		Presbyterian		UHC	
	#	%	#	%	#	%	#	%
Abuse	7	7%	30	17%	20	9%	21	11%
Death	7	7%	11	6%	17	8%	23	12%
Elopement/Missing	0	0%	0	0%	1	0%	0	0%
Emergency Services	65	66%	112	64%	143	67%	132	67%
Environmental Hazard	0	0%	1	1%	2	1%	2	1%
Exploitation	7	7%	9	5%	11	5%	10	5%
Law Enforcement	3	3%	5	3%	7	3%	3	2%
Neglect	9	9%	7	4%	14	7%	6	3%
Total	98		175		215		197	

Action Plans

MCOs began DY3 with six internal corrective action plans in progress. During the year, sixteen action plans were proactively initiated by the MCOs, of which six were closed, one was moved to a directed corrective action plan and nine are in progress. While there is no particular trend, HSD notes that four of the sixteen internal corrective action plans initiated this year were related to regulatory reporting and five were related to audit findings (e.g. Care Coordination, External Quality Review Organization (EQRO), claims, and encounter audits). For additional details, a summary and progress updates are provided as an attachment with each quarterly report.

Evaluation Activities

During the course of DY1 and DY2 of Centennial Care, HSD researched all data points for the 125 measures detailed in the 1115 Demonstration Waiver Evaluation Design Plan, dated April, 2, 2014. HSD determined 13 of the measures lacked data sources and 2 measures needed to be modified.

On February 17, 2017 HSD received tentative approval from CMS to remove the 13 measures from the evaluation design plan and modify the other 2. The measures, HSD requested action, CMS response, and HSD follow-up action on March 8, 2017 are detailed in the table below.

Table 12 – Changes to the Evaluation Design Plan

Measure	HSD requested action	CMS response	HSD follow-up
Number and percentage of acute care participants with a follow-up outpatient visit 7 days and 30 days after hospitalization	Remove	Concur to remove	Removal of measure from evaluation
Number and percentage of behavioral health participants with follow-up after hospitalization for mental illness	Modify language to align with HEDIS. Number and percentage of behavioral health participants with follow-up visit 7 days and 30 days after hospitalization for mental illness.	Concur to remove and modify upon validation of metrics.	Validation of metrics and modification of measure language to align with HEDIS
Number and percentage of participants receiving HCBS whose Individualized Service Plans (ISPs) address all assessed needs from the comprehensive needs assessment (services and supports needed to live in the community)	Remove	Concur to remove	Removal of measure from evaluation
Number and percentage of participants receiving HCBS whose services were delivered in accordance with the ISP (type, scope, amount and frequency)	Remove	Concur to remove	Removal of measure from evaluation
Neonatal mortality rate (AHRQ Pediatric Quality Indicators)	Remove	Request for additional details regarding alternative data sources explored	Submitted requested information on alternative data. Provided detail of current measures that support pregnancy/infant outcomes
Number and percentage of births pre-term	Remove	Request for additional details regarding alternative data sources	Submitted requested information on alternative data.

		explored	Provided detail of current measures that support pregnancy/infant outcomes
Low birth weight rate (AHRQ Prevention Quality Indicators)	Remove	Request for additional details regarding alternative data sources explored	Submitted requested information on alternative data. Provided detail of current measures that support pregnancy/infant outcomes
Use of appropriate medications for people with asthma	Remove	Concur to remove	Removal of measure from evaluation
Drug overdose mortality rate	Remove	Concur to remove	Removal of measure from evaluation
Linkage to HIV medical care: number of persons with HIV who attended a routine HIV medical care visit within 3 months of HIV diagnosis	Remove	Concur to remove	Removal of measure from evaluation
Retention in HIV medical care: number of persons with HIV who had a least one HIV medical care visit in each 6-month-period of the 24-month measurement period	Remove	Concur to remove	Removal of measure from evaluation
Antiretroviral therapy (ART) among persons with HIV medical care: number of persons with HIV who are prescribed ART in the 12-month measurement period	Remove	Concur to remove	Removal of measure from evaluation
Use of antipsychotics for children under 5 years enrolled in foster care	Remove	Concur to remove	Removal of measure from evaluation
Treatment adherence-bipolar	Remove	Concur to remove	Removal of measure from evaluation
Amount of federal waiver reporting and oversight-number of reports and staff time	Remove	Concur to remove	Removal of measure from evaluation

Progress under the work plan continued throughout 2016 for the evaluation of Demonstration Year 2 (DY2) of the Centennial Care 1115 Waiver. With nearly all data collected, there was a shift toward completing tasks required to support the development of the DY2 Annual Report due April 2017 to HSD.

The completion of major activities consisted of finalizing all of the data and report collection efforts, analyzing the data, and making preparations to begin drafting the DY2 Annual Evaluation Report. An initial outline for the Annual Report was formed; incorporating key feedback from HSD based on a retrospective review of the DY1 work plan and completed activities. In addition, since November 2016, Deloitte began collecting DY3 reports and data from HSD and has initiated preliminary review.

Deloitte met with HSD during regular weekly conference calls and onsite meetings as needed to further refine the work plan, discuss data and data questions, as well as identify and review any analysis issues or risks.

Deloitte will highlight a set of approximately 15 reportable measures to illustrate progress under the Centennial Care 1115 waiver in terms of access, quality, and cost for the DY2 Annual Report. The executive summary and body of the DY2 Annual Report will focus on program-level highlights and conclusions from observing these specific measures, as well as key indicators of performance in detail. An appendix to the Annual Report will provide additional data for reported measures in greater detail, such as additional breakouts of the data by member age bands and gender, MCO, and/or other meaningful distinctions specific to each measure.

Interim Findings

The Evaluation Plan for Centennial Care set out four goals for the waiver, each with its own hypothesis and related research questions. Each research question had multiple performance measures to be assessed to determine the extent to which Centennial Care is achieving its goals through the implementation of the waiver.

The Annual Report will include an overall analysis of data review across each evaluation measure in relation to HSD's hypothesis and related research questions. The report will also provide an evaluation of HSD's performance in operating the waiver program during DY2 and provide a comparison to DY1 and the established baseline. Below are some preliminary interim findings of the evaluation.

Research Question 1.A.: Has Centennial Care impacted access to care for all populations and services covered under the waiver, including physical health, behavioral health, and long term support services?

- For Q1 of CY 2016, the percentage of open PCP practices increased from Q1 of CY 2015 from 93.4% to 94.2%. This also represents an increase from 88.4% in Q1 of CY 2014.

- The percentage of Native Americans opting into Centennial Care was 25% at the end of DY1 and 29% at the end of DY2. As of November 14, 2016 nearly 33% of Native Americans had opted into Centennial Care, indicating the trend of opting in has continued for all three years of the program's existence.

Research Question 1.C.: Are care coordination activities meeting the goals of right amount of care, delivered at the right about of time?

- There were fewer readmissions to NF from HCBS (seven during Q4 CY 2015 vs four in Q1 of 2016); however, there were also fewer transitions from HCBS to NF (26 in CY 2015 vs. 20 in CY 2016) and with only a slight drop in total members within Nursing Facilities.

The number of HCBS services used during the year as a percentage of those prescribed in the care plan dropped from Q4 CY 2015 to Q1 CY 2016 however, the Q1 CY 2016 data is not yet complete.

Quality Assurance Monitoring Activities

Care Coordination

Following up on a November 2015 desk audit which evaluated MCO care coordination activities, HSD monitored monthly progress reports from the MCOs. These progress updates outlined the MCOs' efforts to improve care coordination practices according to HSD's recommendations and action steps. The MCOs reported they continue to provide training on documentation as well as contract and policy requirements for their care coordination teams. In January 2017, a report will be provided to the MCOs on their monthly progress updates. HSD also scheduled meetings with the MCOs in February 2017 to review systemic progress and additional requirements to ensure correction of audit findings. An ongoing quarterly HSD care coordination and MCO meeting will be implemented for DY4.

In June 2016, HSD provided additional training on documentation best practices and expectations to the MCOs' care coordinators, trainers, managers and auditors to improve targeted areas identified in the November 2015 audit. Areas addressed included aligning PH and BH needs identified from the Comprehensive Needs Assessment (CNA) with the Comprehensive Care Plan (CCP) goals, enhancing falls documentation, individualizing and distinguishing between backup and disaster plans, and effectively capturing on-going care coordination activities and member feedback. HSD also trained care coordinators in best practices for utilizing the CNA, CCP, and the standardized Health Risk Assessment (implemented in DY3). HSD intends to conduct an additional documentation training for care coordination in DY4 based upon the ongoing monitoring of the MCOs' internal care coordination audits.

HSD also conducted "ride-alongs" with MCO care coordinators in July and August 2016 to observe member visits in the home setting. HSD reviewed ride-along experiences with the

MCOs identifying the need to continue care coordination training on member assessments and available services. Modifications to assessment tools and technical assistance were provided to the MCOs based on the observations. MCOs acknowledged the need for continued training and that the process was helpful to the MCO care coordinators. In DY3, HSD developed a process and evaluation tool for DY4 ride-alongs to more consistently evaluate care coordination activities. The ride-alongs will focus on utilization by care coordinators of the Community Benefit Services Questionnaire (CBSQ), a tool developed collaboratively by HSD and the MCOs to educate members about available home and community based services. HSD will also be observing the care coordinator's use of the Community Benefit Member Agreement (CBMA), to document if the member agrees to accept or decline available services.

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 DY3.

Table 13 – 2016 Service Plan Audit

Service Plans	Quarter 1 2016	Quarter 2 2016	Quarter 3 2016	Quarter 4 2016	CY 16 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 (NFLOC)

HSD continues to review high NFLOC and low NFLOC denials on a quarterly basis to ensure the denials were appropriate and based on NFLOC criteria.

Table 14 – 2016 NFLOC Audit

	Quarter 1 2016	Quarter 2 2016	Quarter 3 2016	Quarter 4 2016	DY3 Totals
High NFLOC requests denied (and downgraded to Low NF)					
Number of member files audited	10	17	18	16	61
Number of member files that met the appropriate level of care criteria	10	17	18	16	61
Percent of MCO level of care determination accuracy	100%	100%	100%	100%	100%

	Quarter 1 2016	Quarter 2 2016	Quarter 3 2016	Quarter 4 2016	DY3 Totals
Low NFLOC requests denied (Community Benefit)					
Number of member files audited	16	20	20	20	76
Number of member files that met the appropriate level of care criteria	16	20	20	20	76
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 15 – 2016 EQRO NFLOC Review

Facility Based	Quarter 1 2016	Quarter 2 2016	Quarter 3 2016	Quarter 4 2016	DY3 Totals
High NF Determination					
Number of member files audited	24	28	26	23	101
Number of member files the EQRO agreed with the determination	18	20	19	20	77
%	75%	71%	73%	87%	77%
Low NF Determination					
Number of member files audited	84	80	82	85	331
Number of member files the EQRO agreed with the determination	83	78	82	85	328
%	99%	98%	100%	100%	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	153	154	154	616
%	99%	98%	99%	99%	99%

HSD will continue to monitor the EQRO audit of MCO NFLOC determinations and address trends identified.

Post Award Forum

The Centennial Care post award forum was held on Monday, November 14, 2016 as part of a regular Medicaid Advisory Committee (MAC) meeting where meaningful comments about the progress of Medicaid's Centennial Care program since implementation. HSD will utilize the valuable information gained during the public forum from MAC members, Centennial Care members, advocates and providers, to assist in its continued efforts to improve services, healthcare outcomes and member satisfaction.

The public forum offered a broad range of comments, for example, parents of children with special healthcare needs requested notice of provider changes and an increase in the number of

Respite hours offered through the Community Benefit program. However, some of the strongest comments offered came from advocates and providers regarding increasing provider-based care coordination and expand services to address social determinant of health.

In October 2016, HSD convened a subcommittee of the MAC to begin planning for the 1115 waiver renewal where some of the issues raised were discussed as focus areas for the renewal. In addition, HSD is discussing ways to expand on provider level care coordination in the next MCO contract amendment that will be effective January 2018.

SECTION III: TOTAL ANNUAL EXPENDITURES

Table 16 – Waiver Year 3 Expenditures

Medicaid Eligibility Group (MEG)	Program Expenditures	Administrative Expenditures
MEG01 - TANF & Related	$1,462,319,710	$63,639,623
MEG02 - SSI & Related - Medicaid Only	$868,969,133	$6,939,202
MEG03 - SSI & Related - Dual Eligible	$593,582,822	$6,287,159
MEG04 - "217 Like" Medicaid Only	$7,962,326	$32,468
MEG05 - "217 Like" Dual Eligible	$90,826,284	$432,037
MEG06 - VIII Group - Medicaid Expansion	$1,490,021,951	$45,153,651
MEG07 - CHIP	$117,219,486	$8,678,227
Uncompensated Care "UC" Pool	$51,667,000	N/A
Hospital Quality Improvement Incentive "HQII" Pool	$5,764,727	N/A
Grand Total	**$4,688,333,439**	**$131,162,367**

Source: New Mexico CMS 64 Submissions, FFY16 Quarter 2 through FFY17 Quarter 1

SECTION IV: YEARLY ENROLLMENT REPORT

Table 17 – Demonstration Year 3 Enrollment

Demonstration Population		
	DY3 Member Months (as of 1/13/17)	DY3 Enrollment (as of 1/13/17)
Population 1 – TANF and Related	1,164,772	366,185
Population 2 – SSI and Related – Medicaid Only	123,671	41,331
Population 3 – SSI and Related – Dual	110,726	40,140
Population 4 – 217-like Group – Medicaid Only	624	370
Population 5 – 217-like Group – Dual	8,277	3,325
Population 6 – VIII Group (expansion)	786,737	334,292
Totals	2,194,807	785,643

Note: This data was extracted on January 13, 2017. 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.
- Continued efforts to improve access to specialty providers. Increased access to both physical and behavioral health care through an expanded utilization of telemedicine in rural and frontier settings.
- 248,513 "unreachable" members were successfully reached by the MCOs during the Unreachable Member Campaign (September 2014 – June 2016).
- Expanded directly acting antiviral coverage from two of the seven stages of Hepatitis C (F3 and F4) to the five stages for which there is medical evidence indicating the benefit of treatment (F2, F3, F4, decompensated cirrhosis, hepatocellular carcinoma).
- A Secret Shopper Survey of providers was conducted in August 2016, to inform Access monitoring.

Care Coordination for Justice-Involved Individuals

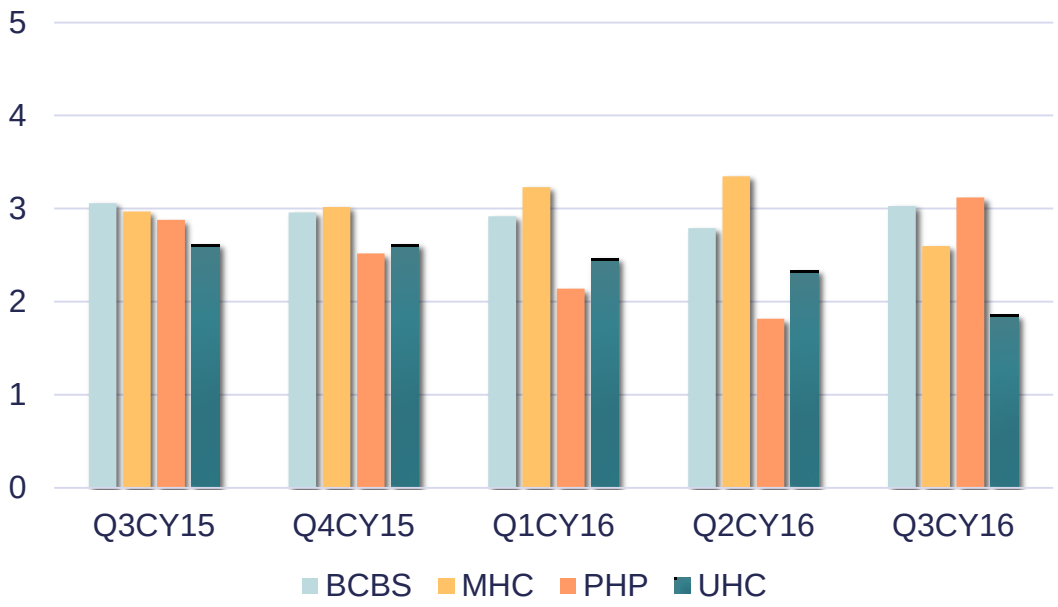
HSD continues to provide technical assistance for the pilot project of one of the MCOs which involves a sample population of justice-involved members. The project focuses on providing these members with care coordination to address members' immediate needs upon release, potentially bridging gaps in care. The MCO will present data findings for its sample of incarcerated members participating in the pilot project to inform future expansion of corrections engagement in Centennial Care.

Super Utilizer Project

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 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 2015, HSD began tracking the top ten members for each MCO. In DY3, HSD began tracking the top 35 super utilizers per MCO.
- The MCOs developed recommendations for better management of super utilizers.
- In DY4, HSD intends to conduct inferential statistical analytics to determine predictors of ED utilization and to share significant results will all MCOs.
- The following graph illustrates average quarterly ED visits for each of the MCOs' top 35 super utilizers:

Table 18 – Average Quarterly ED Visits for Top 35 High Utilizers per MCO



Other MCO Efforts to Reduce Non-emergent Emergency Room Use

- Enhanced efforts to engage historically unreachable members;
- Assigning Community Health Workers to high utilizers;
- Piloting programs with Emergency Medical Technicians to visit members;
- Purchasing EDIE software for instant notification when a member is in the ER;
- Patient Navigator program contacted by hospital to triage members and direct them to more appropriate setting such as Urgent Care;
- Video physician visits have been implemented by all MCOs with ability to assess through an app on smart phones.

Report Revisions to Reduce MCO Variations

HSD requested recommendations from all MCOs and internal stakeholders to reduce administrative burden by streamlining reports, which included report revisions to reduce MCO variations, combining reports elimination of reports, and adding reports. Revisions to the reports are in various stages and HSD will provide an update in DY4 Q1.

Improved Reporting Process

During DY3, HSD observed significant advancements made by the MCOs regarding the reporting process:

- MCOs have demonstrated an increased capacity to improve their reporting skills by applying a more quantitative data analytics methodology to how they identify, interpret and analyze the significance of data elements and trends.

- HSD Subject Matter Experts (SMEs) found that utilizing a consultative approach with MCOs has proven to be valuable in obtaining meaningful, data-driven reports.
- HSD developed and implemented quality improvement initiatives and tools for MCOs to use in effectively evaluating the accuracy of HSD required reports.
- HSD launched a Technical Assistance (TA) Call process that continues to enhance collaboration with MCOs, by providing an educational opportunity for MCOs to openly dialogue with HSD management about reporting issues and concerns. The exchange of information, along with HSD's guidance, has produced positive outcomes.
- HSD has streamlined MCO reporting procedures resulting in effective monitoring and tracking of managed care reports.

Health Homes

On April 1, 2016 HSD launched the first two Health Homes, CareLink NM (CLNM), with the designated population of adults with a serious mental illness and children/adolescents with a severe emotional disturbance. The provider base was restricted to two rural counties so processes could be tested and evaluated. The 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 resultant support and oversight. The goals include: 1) health promotion/prevention, 2) improvement of acute and long term health, 3) enhancement of member engagement and self-efficacy, 4) improvement of quality of life for members, and 5) the reduction of 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 the outcomes.

The development of the automated information system, BHSD Star, was launched with the first modules of registration, service charting, and interfaces to the Medicaid and MCO claims systems activated on April 1st. The remainder of the year was dedicated to refining the policies through experience, and preparing for the next launch. By the close of the year the two Health Homes were already demonstrating positive results.

Delivery System Improvement Performance Targets (DSIPTs)

The DSIPTs allow MCOs to be recognized for their quality improvements in specific areas. In 2014 and 2015, HSD required four target areas for DSIPTs. In DY3, HSD expanded target areas by adding emphasis on five specific areas. HSD is currently evaluating the 2016 MCO results for DSIPT targets in the following areas:

A. *Community Health Workers* - Increase the use of Community Health Workers (CHWs) for care coordination activities, health education, health literacy, translation and community support linkages in Rural, Frontier, and underserved communities in urban regions of the State.

   Community Health Worker 2016 Results - Each MCO utilized CHWs to expand services for their members. In 2016, a total of 41,885 MCO members were served by CHWs. The goal for 2017 is a 10% increase in members served.

B. *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 2016 Results – Utilization of telemedicine continues to increase in both physical and behavioral health. For 2016, there was a total of 16,953 telemedicine visits for all MCOs with 4,181 physical health telemedicine visits and 12,772 behavioral health telemedicine visits, which results in an average total increase of 17% from DY2 to DY3. All MCOs met their respective target by increasing telemedicine by fifteen percent.

C. *Patient Centered Medical Homes* - A minimum of 5% increase of members being served by Patient- Centered Medical Homes (PCMHs) (including both PCMHs that have achieved NCQA accreditation and those that have not) or maintain a minimum of 40 percent.

Patient Centered Medical Homes 2016 Results –PCMH membership in 2016 equals 290,789 members. All MCOs met their respective target by increasing PCHMs by 5% or maintaining a minimum of 40% of members served by PCMHs.

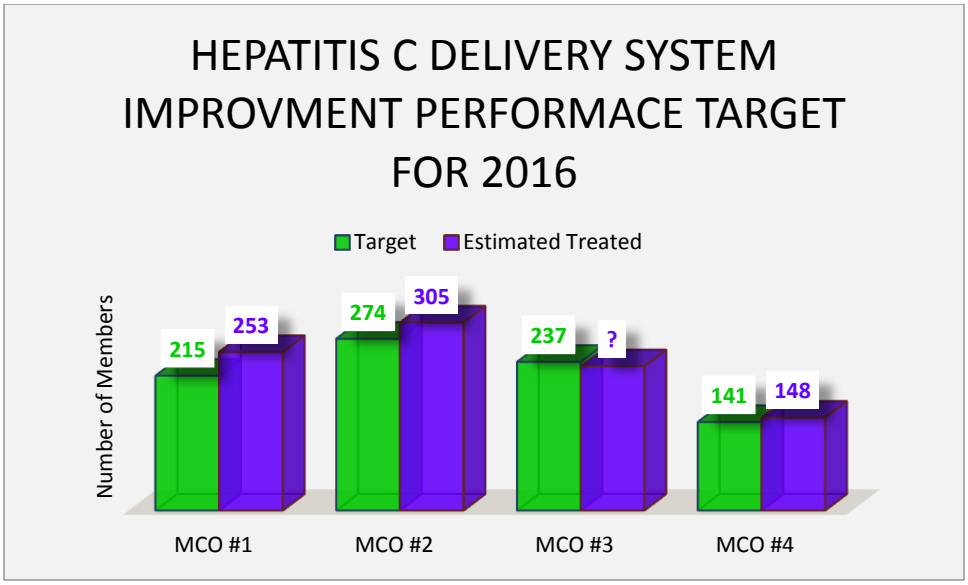
D. *Behavioral Health* - Percent of seven-day follow-up visits into community-based behavioral health care for child and for adult members released from inpatient psychiatric hospitalization stays of four or more days. Due to claims lag a final target ranging between 10 – 15 percent improvement will be established in consultation with MCOs and national standards after submission of the annual report.

Behavioral Health 2016 Results – All MCOs met their respective target.

E. *Hepatitis C* - MCOs must treat at least 50% of Hepatitis C drug treatments for the combined Physical Health, Medicaid Only LTSS, and Other Adult Group populations during the contract period.

Hepatitis C 2016 Results - In DY3, the target number of members to be treated was 867 members for all MCOs. Utilizing encounter data in 2016, an estimated 935 members have been treated. HSD is working with one MCO to identify discrepancies within the encounter data to determine if the target was met or not met. All other MCOs met the respective target established. Please see Table 19: Hepatitis C Delivery System Improvement Performance Target for 2016.

Table 19 – Hepatitis C Delivery System Improvement Performance Target for 2016



Source: Centennial Care – CY16 Hepatitis C Delivery System Improvement Target

Community Health Workers

In DY3, all four MCOs included key initiatives to address barriers and access to care, with the use of Community Health Workers (CHWs). CHWs are specifically trained to identify and address the social determinants of care that improve health outcomes, by use of coordination of care, culturally appropriate health education, and health literacy, interpretation and translation services, and community support linkages in rural, frontier, and underserved communities in urban regions.

All MCOs completed DY3 with CHWs that are either employed or contracted, for a total of sixty-three (63) CHWs. MHNM has reported that eight employed CHWs are certified. Please see Table 20: DY3 Community Health Workers.

Table 20 – DY3 Community Health Workers

	Employed	Contracted
BCBSNM	0	12
MHNM	26	0
PHP	5	9
UHC	11	0
Total per MCO	42	21
Total for All MCOs	63	

Source: [MCO] DSIPTs, Q4CY16

Both BCBSNM and MHNM partnered with the University of New Mexico Health Sciences Center ((UNM HSC), Office for Community Health pilot program, Integrated Primary Care and

Community Support (I-PaCS), previously referred to as the Community Health Improvement through Strengthened Partnership, Access and Support (CHISPAS).

The I-PaCS model utilizes screening for social determinates with an assessment to support the CHWs to more specifically address the needs of members identified as "at risk" based on such indicators as frequent emergency room use, chronic conditions and complex behavioral health conditions.

In July 2016, UNM HSC provided an I-PaCS report from 3,048 survey responses that indicated that among the top most common social determinates of health are utility access and access to food resources. Of those surveyed 1,413 or 46% had one social determinate, 792 or 26% had two to five, and 98 or 3% had six to eleven.

CHWs offer food vouchers for emergency food boxes and phone numbers for local food pantries and food bank partners. A prescribed food program has begun to assist members to select foods that specifically address such chronic conditions as diabetes. To address the barriers to utilities, CHWs provide phone numbers for the Low-Income Home Energy Assistance Program, (LIHEAP), social services and community partners, such as St Vincent de Paul and The Salvation Army, which provide rent, utilities, food assistance, clothing, and other supports, such as health education.

CHWs were able to successfully engage many difficult to engage members and unreachable members to complete Health Risk Assessments, offer care coordination, find a primary care physician, and assist with transportation needs for appointments or attend a member's appointment to provide support. One MCO reported that 38% of CHW interventions were locating members and completing an HRA.

CHWs assisted care coordination to engage 25% of members identified as both high risk and difficult to engage. Of those declining care coordination, 100% agreed to quarterly contact from a CHW. Another MCO successfully reached 55% of the persistent super-utilizers and 36% agreed to be followed by care coordination. Those declining indicated that they had a family member, hospice or institution to assist them with their needs.

CHWs provided education outreach and promotion with a focus on the following highlights for DY3:

- Primary care physician importance
- Preventative care benefits & incentives
- Health literacy, for improving engagement and self- management
- Pregnancy care
- Diabetes
- Hepatitis C

- Flu season preventatives
- Zika virus information

Utilization Data

Centennial Care key utilization and cost per unit data by overall program as well as by specific program for DY2 and DY3 can be found in Attachment K – Key Utilization/Cost per Unit Statistics by Major Population Group.

Progress On Implementing Payment Reform Initiatives

Value Based Purchasing Initiatives

A key program goal of Centennial Care has been based on pay for value and not solely volume of services rendered by rewarding achievements in quality of care and member health outcomes. To support this goal, HSD expanded its current payment reforms by increasing the percentage of payment arrangements that are risk-based. In DY4, Centennial Care MCOs are required to have 16% of all provider payments in one of three levels of VBP payment arrangements:

- At least 5% in Level 1: Incentives and Withholds.
- At least 8% in Level 2: Shared Savings and bundled payments.
- At least 3% in Level 3: Some or full-risk capitation.

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 continued to require the MCOs to include 14 supplemental questions approved by the National Committee Quality Assurance (NCQA) on the CAHPS survey for 2016.

Below is a table with the supplemental questions and results submitted for 2015 and 2016.

CAHPS Supplemental Questions *CCC-Children with Chronic Conditions *N/A- Not Reported	Year	BCBS		MHC		PHP		UHC	
Child Care Coordination									
1. In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these doctors or other health providers? (% answering Yes)	2015	27%	43% CCC	64%	71% CCC	52%	60% CCC	N/A	
	2016	28%	28% CCC	27%	44% CCC	14%	29% CCC	56%	51% CCC
2. In the last 6 months, who helped to coordinate your child's care?									
Someone from your child's health plan	2015	4%	8% CCC	13%	14% CCC	4%	9% CCC	N/A	

	2016	6%	6% CCC	5%	6% CCC	13%	20% CCC	5%	10% CCC
Someone from your child's doctor's office or clinic	2015	19%	22% CCC	55%	48% CCC	48%	50% CCC	N/A	
	2016	22%	22% CCC	24%	31% CCC	63%	57% CCC	29%	35% CCC
Someone from another organization	2015	1%	4% CCC	6%	10% CCC	6%	7% CCC	N/A	
	2016	3%	3% CCC	2%	4% CCC	0%	6% CCC	2%	6% CCC
A friend or family member	2015	5%	6% CCC	1%	1% CCC	3%	3% CCC	N/A	
	2016	4%	4% CCC	5%	3% CCC	9%	3% CCC	6%	3% CCC
You	2015	71%	60% CCC	25%	27% CCC	39%	31% CCC	N/A	
	2016	65%	65% CCC	64%	56% CCC	16%	14% CCC	59%	46% CCC
3. How satisfied are you with the help you received to coordinate your child's care in the last 6 months?									
Satisfied or Very Satisfied	2015	81%	74% CCC	86%	87% CCC	91%	88% CCC	N/A	
	2016	77%	77% CCC	90%	86% CCC	86%	87% CCC	84%	77% CCC
Adult Care Coordination									
4. In the last 6 months, did anyone from your health plan, doctor's office, or clinic help coordinate your care among these doctors or other health providers? (% answering Yes)	2015	33%		24%		27%		N/A	
	2016	38%		30%		29%		37%	
5. In the last 6 months, who helped to coordinate your care?									
Someone from your health plan	2015	9%		19%		17%		N/A	
	2016	14%		12%		34%		12%	
Someone from your doctor's office or clinic	2015	25%		48%		47%		N/A	
	2016	26%		23%		48%		21%	
Someone from another organization	2015	2%		3%		4%		N/A	
	2016	4%		1%		1%		5%	
A friend or family member	2015	14%		16%		13%		N/A	
	2016	14%		11%		8%		23%	
You	2015	50%		16%		19%		N/A	
	2016	43%		53%		9%		39%	
6. How satisfied are you with the help you received to coordinate your care in the last 6 months?									
Satisfied or Very Satisfied	2015	80%		87%		88%		N/A	
	2016	74%		81%		94%		79%	
Member Education									

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

In order to compare among the MCOs, HSD calculated the averages of all the percentages reported by the MCOs for each response above.

Child Care Coordination:

Question 1 - the average MCO percentages for those answering "Yes" decreased from 2015 to 2016 for both Child and CCC measures.

Question 2 - the average MCO percentages increased from 2015 to 2016 for those answering "Someone from your child's health plan" and "You" for both Child and CCC measures.

Question 3 - the average MCO percentages decreased from 2015 to 2016 for those answering "Satisfied" or "Very Satisfied" for both Child and CCC measures.

In comparing the results of the 2015 to 2016 supplemental questions related to Child Care Coordination, Child and CCC results do not show an overall improvement from year to year. Of the three MCOs reporting for both years one MCO improved in child care coordination by 1%

and one MCO improved in child care coordination member satisfaction by 4%. One MCO improved in care coordination for the CCC population by 3%.

Adult Care Coordination:
Question 4 - the average MCO percentages for those answering "Yes" increased from 2015 to 2016.

Question 5 - the average MCO percentages increased from 2015 to 2016 for those answering "Someone from your child's health plan" and "You."

Question 6 - the average MCO percentages decreased from 2015 to 2016 for those answering "Satisfied" or "Very Satisfied."

In comparing the results of the 2015 to 2016 supplemental questions related to Adult Care Coordination, results do show an overall improvement from year to year. Of the three MCOs reporting for both years all three improved on care coordination by 5%, 6%, and 2%, respectively, and one of the three reporting improved on satisfaction with care coordination by 6%.

Member Education:
Question 7 - the average MCO percentages increased from 2015 to 2016

Question 8 - the average MCO percentages increased from 2015 to 2016.

In comparing the results of the 2015 to 2016 supplemental question related to Member Education for the Adult populations, all three MCOs reporting for both years improved on providing materials to members on care coordination by 10%, 6%, and 1%, respectively. Two out of the three MCOs improved on providing materials to members regarding good health by 15% and 1%, respectively.

Care Plan:
Question 9 - the average MCO percentages for those answering "Yes" decreased from 2015 to 2016.

Question 10 - the average MCO percentages increased from 2015 to 2016 for those answering "Satisfied" or "Very Satisfied."

In comparing the results of the 2015 to 2016 supplemental questions for a Care Plan, two of the three MCOs reporting for both years improved on creating a care plan by 4% and 1%, respectively. Only two MCOs reported for both years on member satisfaction, and one MCO improved by 12% and the other remained the same for both years.

Fall Risk:
Question 11 - the average MCO percentages for those answering "Yes" decreased from 2015 to 2016.

Question 12 - the average MCO percentages increased from 2015 to 2016.

Question 13 - the average MCO percentages increased for those answering "Yes" from 2015 to 2016

Question 14, the average MCO percentages increased for those answering "Yes" from 2015 to 2016.

**Note that for Questions 12 and 13 an increase does not show improvement.*

In comparing the results for the 2015 to 2016 supplemental questions regarding Falls, two out of the three MCOs report improvement of members talking to their doctor about falling or problems with balance or walking by 1% and 35%, respectively One MCO improved by 3% on questions related to falling in the last six months, all three MCO reporting improvement by 1%, 4%, and 4%, respectively, on questions related to problems with balance or walking, and two MCOs improved by 3% and 32%, respectively, on preventing falls or treating problems with balance or walking.

Annual Summary of Network Adequacy by Plan

All of the MCOs implement policies and processes to diligently monitor and evaluate network adequacy in an effort to render adjustments as needed. 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 contemplate the need for sufficient accessibility and availability for medically necessary services for the current and new population, assesses the current unmet needs and future needs related to membership growth.

MCOs utilize Report #3, the Network Adequacy Report, to evaluate provider ratios 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 F – GeoAccess PH Summary.

- BCBSNM enrollment increased by 11,148 members in DY3. This represents an annual increase of 8.56% or approximately .74% increase per month in membership during DY3. Assuming similar trends in DY4, BCBSNM estimates total enrollment in December 2017 will be approximately 154,000. This estimate will be used as one of the analytical tools to guide BCBSNM's on-going network development.

- MHC reports that they currently have a network that will be more than adequate to provide medically necessary covered services for its projected membership growth for DY4. Its membership increased from December 2015 to December 2016 by 9,110

members or 4.06%. The projection for membership in 2017 calls for a more conservative growth rate of about 1% overall.

- As of December 31, 2016, PHP has an increase of 10% compared to 2015. PHP is projecting approximately one percent growth in membership for 2017. Based on the combined growth in DY3 and the projected growth in DY4, PHP analyzed the Centennial network and determined that it is sufficient to meet the needs of their Centennial members.

- UHC is not projecting significant growth for DY4. However, there are areas that still need recruitment to meet Geo-Access requirements. UHC acknowledges a need to recruit dermatology (rural and frontier), endocrinology (rural and frontier), neurosurgeons (rural and frontier), and urology (frontier) providers for current and anticipated growth needs.

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 members who had HCBS services under a section 1915 (c) waiver and continued to meet the NFLOC criteria upon transition to Centennial Care. HSD identified a universe of members who had transitioned from a 1915 (c) waiver enrolled for each MCO. The MCOs were directed to submit a universe of members who had a reduction in Personal Care Service (PCS) hours during Calendar Year 2015 and HSD selected a random sample of 30 charts for each MCO review.

Blue Cross Blue Shield audits revealed the reduction in PCS hours were appropriate and included reasons such as member improvement, increases in natural supports and shared households.

Molina Healthcare provided 30 member charts that included 24 members with reductions in hours, five member charts that did not have a reduction and one member chart that actually showed an increase in hours. Of the 24 member charts reviewed, 21 member charts presented documentation that the PCS hours were appropriately reduced and three member charts had reductions of two hours or less that did not include supporting documentation. HSD reached out to Molina Healthcare for additional information regarding the three members and received confirmation that two of the members had their hours corrected citing reviewer error and the third member had declined community benefits. Molina Healthcare implemented a process for secondary review by a manager or supervisor in 2016 and continues to provide annual training on record review, regulations and new State directions affecting authorizations.

HSD requested from Presbyterian Health Plan additional documentation for seven of the 30 member charts provided to evaluate the reduction in hours. All 30 member charts for Presbyterian Health Plan had PCS reduction in hours that were appropriate in relation to member improvement or increase in natural supports or shared households.

United Healthcare audits had two member charts that did not reveal a reduction in PCS hours, 1 member chart showed the member had improved and had decreased needs, eight member charts showed the reduction in PCS hours were related to the member having natural supports or a shared household and 19 member charts did not have documentation showing any correlation between the member's unchanged condition, supports or housing with the reduction in PCS hours. HSD requested United Healthcare provide an analysis for the 19 member charts that did not have supportive documentation for the reduction. United Healthcare reports that 16 members belonged to another MCO prior to Centennial Care and honored the allocated hours in 2014 but did not receive documentation from the transferring MCO making it unclear how services were determined for the PCS hours allocated. United Healthcare also states all reductions taken to Appeals and Fair Hearings were upheld. Of the remaining three members, two members actually had an increase in hours and the perceived reduction was related to data entry errors. The third member did experience a reduction in PCS hours which was upheld on appeal.

All 4 MCOs were directed to continue training on clear, concise and comprehensive documentation for member records.

Table 21 – DY3 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	3	0
Number of files with no reduction or increase	0	0	5	2
Number of files which showed an increase	0	0	1	2
Number of files with appropriate reduction	30	30	21	26

Myers & Stauffer Evaluation

Myers and Stauffer, LC provided final reports of its 2015 audit findings for inpatient paid and denied hospital claims (including claims adjudication, prior authorization and provider credentialing) to HSD in March 2016. HSD responded to the Myers and Stauffer recommendations relating to HSD policy. The primary change was to include a timeliness requirement, 45 days, for MCO contract loading following provider credentialing. Revisions were made in Contract Amendment #7, effective July 1, 2016. Concurrently, HSD evaluated Myers and Stauffer findings related to MCO policies and processes. Each MCO responded to HSD regarding the audit findings. BCBSNM initiated an internal corrective action plan; updates HSD monthly; and, anticipates completion of its plan in Q1 DY4. HSD issued notice of a formal directed corrective action plan (DCAP) to UHC on August 18, 2016. Two of the six items in the

DCAP, regarding credentialing and the need for improved oversight of delegated entities, have been sufficiently addressed and are now closed.

Regarding the remaining four items in the UHC DCAP, UHC has been working closely with the New Mexico Hospital Association (NMHA) to address specific provider concerns and has also made significant policy changes. In addition, UHC contracted with Ernst & Young, LLP (EY) to provide an independent evaluation of the items in the DCAP specifically related to claim payments and denial rates. Effective July 1, 2016, UHC implemented a policy which provides additional time for hospitals to provide clinical documentation for hospital admissions. The policy is intended to: reduce provider administrative burden; improve claim denial rates; and, reduce the need for provider appeals. In addition, beginning March 1, 2017, providers will be able to submit an informal request for medical necessity review on denied claims while preserving the right to a formal claims appeal. This policy is intended to: "increase provider satisfaction through ease of submission and faster turnaround times; drive down claim appeals; [and] reduce claims appeal overturn rate." EY's review will provide data to demonstrate the effectiveness of the July policy change; validate claims using UHC's manually priced claims methodology; and, measure claim adjudication timeliness for manually priced claims. Final reports from EY are due at the end of March 2017.

Summary of Performance Improvement Projects

Pursuant to the Centennial Care Contract, MCO Performance Improvement Projects (PIPs) focused on the following areas in DY3:

1. Services to Children

2. Long Term Care (LTC) Services

The MCOs were directed by HSD to continue with the Quality Improvement Projects (QIPs) associated with the Adult Medicaid Quality Grant (AMQG) which expired in December 2015. The MCOs will develop their Performance Improvement Projects (PIPs) for 2016 with the expectation that each PIP address the prescribed indicators of each domain 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

HSD has contracted with HealthInsight as the External Quality Review Organization (EQRO) to assess measures and validate the above four PIPs. The PIPs associated with the AMQG were not included in the EQRO review for 2015, but will be validated in 2016.

CMS EQR Protocol 3

The EQRO review of the PIPs follows the EQR protocol 3 published by CMS. Protocol 3 specifies procedures to use in assessing the validity and reliability of the PIPs submitted by the MCOs. Protocol 3 details the following 3 activities to be conducted by the EQRO:

1) Assess the study methodology
    a. Review the selected study topic
    b. Review the study question
    c. Review the selected study indicators
    d. Review the identified study population
    e. Review sampling methods
    f. Review the data collection procedures
    g. Assess the MCOs improvement strategies
    h. Review the data analysis and interpretation of study results
    i. Assess the likelihood that reported improvement is "real" improvement
    j. Asses the sustainability of documented improvement

2) Verify PIP study findings (Optional)
3) Evaluate overall validity and reliability of study results

The EQRO has made the determination that each MCO is compliant with Centennial Care contractual and regulatory requirements for both Performance Improvements Plans implemented by each MCO for the 2015 review.

PIPs by MCO for 2015

BCBS	MHC	PHP	UHC
Attention to Dental Health for Children	Diabetes Prevention Program for Youth	Services to Children: Annual Dental Visit	Annual Pediatric Dental Visits
Long-Term Care: Diabetic Eye Exams	Long-Term Support Services: Members with Falls	Inter-Rater Reliability (IRR) for Personal Care Services Allocation	Nursing Facility Transition

Each PIP was evaluated and scored for:

- Demonstrated Implementation of Quality Improvement processes
- Identification of barriers to success
- Quality Improvement strategies and interventions to address the barriers
- Calculation of performance rates (These rates may or may not follow HEDIS technical specifications, depending on what is being measured)

BCBS

PIP#1- Dental Health for Children: BCBS has addressed multiple barriers and placed interventions for those barriers. A barrier addressed by BCBS, is known as, "behavior inertia" which has been identified as members who were unaware of benefits or unmotivated to complete a dental visit. To address this barrier, BCBS increased its campaign to highlight the Centennial Rewards program. Other barriers include deficits for parents/guardians, community health workers, PCPs and dental providers unfamiliar with DentaQuest claims process. BCBS was able to develop and provide various educational and outreach activities to meet all necessary needs. Specific identified members who had not accessed the service were also contacted by BCBS. Since the PIP was introduced in 2014, Dental Health for Children improved by 2% after strategies to address barriers were implemented by BCBS.

CY 2014	CY 2015
59.18%	61.18%

PIP#2 - Long-Term Care: Diabetic Eye Exams has improved by 11.45% from CY 2014 to CY 2015. BCBS continues to identify barriers in order to improve this PIP outcome. For members, knowledge deficits were identified on the diabetes disease process, care guidelines, and navigating health plan benefits and Centennial Reward benefits. BCBS was able to develop and implement educational training and outreach initiatives to address these deficits.

CY 2014	CY 2015
8.90%	20.35%

MHC

PIP#1 - Diabetes Prevention Program for Youth had three subcategories set by MHC: percent of youth in attendance, percent of youth engagement and percent of youth learning. MHC set forth this prevention program in a school based setting, as an early intervention. In CY 2015 the EQRO made the determination that MHC did not meet the definition of a PIP needed for EQRO review. The EQRO has determined that PIP#1 is community outreach, and does not meet a PIP defined as, "a PIP is to assess and improve the processes and outcomes of health care provided by an MCO." Due to the EQRO determination during the review process, the MCO did not have time to submit or complete another PIP, resulting in PIP#1 being labeled as "Not Reportable." MHC introduced this PIP in 2015 and no trending data is available.

PIP#2 - Long-Term Support Services: Member with Falls is designed to decrease the number of fall events. Interventions put in place by MHC are designed to improve the rates of fall events and risks including environmental hazards, cultural barriers, age, chronic conditions, polypharmacy and medications that can affect motor function and cognitive thought. The EQRO was able to evaluate PIP#2 on ten steps, although steps nine and ten (see Protocol 3 above) were

not considered until sufficient data can be collected to assess sustainability. The EQRO was able to establish that PIP#2 met the compliance level. MCH introduced this PIP in 2015 and no trending data is available.

PHP

PIP#1- Services to Children: annual Dental Visit was initiated by PHP to increase annual dental visits in the children. PHP applied interventions to barriers they discovered. PHP was able to identify that members in Southwestern New Mexico, as well as Central New Mexico, had low rates of dental visits, likely due to a limited number of dental providers contracted with Medicaid in these areas. PHP placed calls to members in these areas to assist with scheduling dental exams. A total of 9,222 phone calls were made to members resulting in 476 dental appointments being scheduled. This would be a conversion rate of 5.16%. The EQRO was able to score PHP on PIP#1 with a passing score, meeting the Full Compliance Level for PIP#1. PHP introduced this PIP in 2015 and no trending data is available.

PIP#2 - Inter-Rater Reliability for Personal Care Services Allocation: PIP#2 provided an increased consistency of hours allocated for personal care services among care coordinators. PHP set out to make sure that no matter which care coordinator completes the allocation of hours there is consistent application of criteria and that members are receiving appropriate hours. Current and new employees were trained together and then asked to allocate PCS hours based on carrying scenarios, resulting in an increase in PHP IRR rates from 93% to 99% per MCO data. The EQRO was able to determine that PIP#2 is meeting the full compliance.

CY 2014	CY 2015
93%	99%

UHC

PIP#1- Annual Pediatric Dental Visits: UHC identified members in two categories, members less than 21 years old who received a preventive dental visit during the measurement year and members less than 21 years who received a dental treatment visit during the measurement year. Interventions included various trainings for care coordinators, dental benefits explanations in Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) member information packets, member outreach, and provider education, with the goal to remove barriers. Visits increased by 5.64% for preventive dental and by 2.52% for dental treatment from 2014 to 2015. Per EQRO data, the PIP is in full compliance.

	CY 2014	CY 2015
Preventive Dental Visit less than 21 yrs of age	28.38%	34.02%
Dental Treatment Visit less than 21 yrs of age	14.07%	16.59%

PIP#2- Nursing Facility Transitions, barriers identified focused on the caregiver's knowledge of available community resources and how to care for their loved one once they arrive home. Care Coordinators also provided advice and education on what community resources are available and how to access them. Through education and resource training UHC was able to improve by 0.53% from 2014 to 2015, while also being in full compliance.

CY 2014	CY 2015
1.13%	1.66%

Outcomes of Performance Measure Monitoring

The baseline years for setting 2016 targets and thresholds for all Centennial Care performance measures are 2014 and 2015. HSD established Performance Measure (PM) targets based on the National Committee for Quality Assurance (NCQA), Quality Compass 2015 Health and Human Services (HHS) Regional Averages, and the MCO's 2015 Audited Healthcare Effectiveness Data and Information Set (HEDIS) rates for CY 2014. HSD has contracted with HealthInsight as the EQRO to assess PMs.

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 2015. The MCO performance rates are compared with the average rates reported from the Department of Health and Human Services Region VI for 2015. 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 2015 at least half of New Mexico Medicaid MCOs performed above the regional average in dental visits for members aged 2-21, asthma medication compliance, controlling blood pressure, diabetic eye exams, Hemoglobin A1c testing, and A1c control. The remaining half of the MCOs fell below the average in nephropathy screening, both pregnancy measures, as well as both indicators for antidepressant medication management and follow-up after hospitalization for mental illness.

In comparison to 2014 the MCOs did show improvement in 2015 for some areas. All four MCOs increased performance in Nephropathy Screening for Diabetics and three of the four MCOs increased their performance averages in Annual Dental Visits and Controlling High Blood Pressure.

The MCOs perform well in some areas, however; additional attention is needed in the areas of Prenatal and Postpartum care; Antidepressant Medication Management and Follow up for Hospitalization for Mental Illness. Developing and implementing effective interventions to address these issues remains key to improving the health of the Medicaid population.

MCO Performance Measures

Table 22 – MCO Performance Measures

PMs	BCBS 2014	BCBS 2015	MHP 2014	MHP 2015	PHP 2014	PHP 2015	UHC 2014	UHC 2015	Region VI Average 2015
Annual dental visit									
Ages 2-21	57.46	59.63	62.75	70.07	68.14	66.43	41.52	49.88	60.65
Medication management for people with Asthma (not a PM in 2014)									
Medication compliance 75%		27.85		24.71		28.21		36.91	25.8
Controlling high blood pressure									
Ages 18-85	51.66	56.99	49.88	51.38	55.95	56.42	53.04	49.88	43.53
Comprehensive diabetes care									
Eye Exam	54.23	47.76	56.51	54.53	47.75	46.07	65.21	62.53	44.99
HbA1c testing	83.42	80.43	85.65	88.08	86.52	84.64	84.43	84.43	83.25
Nephropathy screening	78.61	85.07	74.83	88.08	79.53	86.91	83.70	90.27	90.26
Poor control HbA1c (> 9%)	47.26	52.90	48.89	45.03	43.93	48.34	49.15	52.55	44%
Prenatal and postpartum care									
Prenatal care (timeliness)	73.08	72.61	76.80	75.97	77.88	66.36	63.75	67.40	82%
Postpartum visit (frequency)	54.52	57.91	54.50	51.49	61.88	53.13	48.18	41.36	62%
Frequency of ongoing prenatal care									
80% expected visits complete	55.20	50.56	61.04	55.38	48.71	42.92	48.18	34.06	55%
Antidepressant medication management									
Acute treatment	59.97	54.8	53.50	49.55	53.94	53.36	62.50	56.62	52%
Continuous treatment	47.77	39.40	38.63	34.67	38.97	36.24	48.34	42.89	37%
Follow-up after hospitalization for mental illness									
7-days	39.00	34.27	41.80	34.64	43.14	32.56	55.16	54.96	44%
30-days	58.49	55.1	64.80	59.76	67.88	59.75	71.00	73.08	63%

HSD has included eight HEDIS based PMs in the Centennial Care contract for 2016. These PMs will be tracked by the External Quality Review Organization (EQRO) and reported to HSD. The eight PMs with established targets for 2016 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- Frequency of Ongoing Prenatal Care
- PM 7- 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 8- 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.

Calendar Year 2016 Performance Measure Targets require a two percent (2%) improvement above the MCO's 2015 Audited HEDIS rates for Calendar Year 2014, or achievement of the HHS Regional Average or HSD determined target.

Summary of Plan Financial Performance

HSD worked with the MCOs to resolve issues around Nursing Facility Level of Care (NFLOC and Setting of Care (SOC) and timely determination and submission of NFLOC/SOC spans. HSD processed retrospective capitation payments/recoupments. Working through these issues also raised concerns around the categorization of members and their corresponding claims/expenses to the appropriate program/cohort within the financial reports. HSD worked with the MCO's to improve financial reporting. Another area of focus was the improvement and timely submission of encounter data. A report was created to aid HSD's analysis of MCO paid claims to submitted encounters.

With significant improvements made, HSD processed various interim reconciliations for CY2014 and CY2015 that are required under the Centennial Care contract. Final reconciliations have been scheduled and will be completed by the end of the fiscal year 2017.

All MCOs submitted their CY16 fourth quarter financial reports on February 15, 2017. HSD's analysis of quarterly financial reports continues to focus attention on the categorization of expenditures by program, cohort and category of service. Another focus area is the comparison

of reported encounter data to reported financial data. Due to successful collaboration efforts, HSD's has seen significant improvement in both financial reporting and encounter submissions.

To continue to improve financial reporting, to monitor financial contractual compliance and to evaluate the MCOs financial operational performance at both an individual MCO level and an aggregate level, some revisions and updates have been made to financial reporting templates. The revised templates and training were presented to the MCOs. Training focused on common reporting issues for premium revenue, categorization of health care expenses and lag reports. Updates to the templates included the addition of a lag report, a copay report as well as an expenditure and encounter comparison report. Other revisions included some consolidation or additions of health care and administrative expense categories. MCOs will be required to submit the CY16 annual supplement financial reports on May 15, 2017 using the updated templates. HSD will utilize the information provided within the financial reports and encounter data to begin the CY2016 reconciliations that are required under the Centennial Care contract.

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

During the third year of the waiver, data indicated that all MCOs had increases to specialty care visits for psychotherapy, cardiology, orthopedic visits, and ophthalmology for Native Americans. All Centennial Care MCOs continued to work on the numbers of HRAs completed in 2016 for Native Americans, some by partnering with tribal organizations to find "unable to locate" members. The MCOs are also working to increase attendance at their Native American Advisory Board (NAAB) meetings and have extended invitations to tribal leadership.

Also in the third waiver year, three of the four MCOs saw decreased medical admissions rates for Native Americans. The average length of stay also decreased by 65% for two MCOs during 2016. The following chart outlines the top 10 Community Benefits utilized during DY3.

Table 23 – Highest Utilized Community Benefit Services by Native Americans

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

For BH services in frontier areas, all four MCOs met the access to services targets by 90% or more. For PH services, three of the four MCOs met access to care by 90% or more in frontier areas.

In DY3, frequently accessed value added services by Native American members included traditional healing, full coverage Medicaid for pregnant women, followed by enhanced transportation and peer driven recovery oriented services.

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

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; and
- Address issues related to enrollment, access to care and payment for services and review of program data.

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

Table 24 – Schedule of DY3 NAAB Meetings

MCO	Location/Date of Board Meeting	Issues/Recommendations
MHNM	First Nations Clinic Albuquerque, NM March 4, 2016	Molina had about 18 members attend their NAAB. Molina provided information about care coordination, the traditional healing benefit, Value Added Services, Centennial Rewards, their health education programs, telehealth, and addressed comments/questions from the group.
BCBSNM	New Life Homes/Sundowner Apts. Albuquerque March 11, 2016	BCBS provided an overview of their Blue Cross Community Centennial program, discussed recommendations from previous meetings, talked about diabetes education, and invited member feedback and input. About 10 people were present.
PHP	The COOP Auditorium –Albuquerque, NM March 19, 2016	PHP presented on their Native American Affairs program, care coordination, video visits, PresRN program, and answered questions. About 12 people attended the meeting.
UHC	Shiprock Chapter House April 7, 2016	UHC provided lunch and had over 60 people at their NAAB meeting. They talked about care coordination, transportation, outreach updates, and how they can improve their services. Someone requested information about Medically Frail exemption for ABP members.
MHNM	Gallup, NM May 6, 2016	Molina had about 100 members attend this meeting. It was suggested to hold another meeting in Gallup before the end of the year.

MCO	Location/Date of Board Meeting	Issues/Recommendations
BCBSNM	Shiprock Chapter House Shiprock, NM May 27, 2016	There were questions on how the vision benefit works, how to use the member rewards programs, how long it takes to get reimbursed for travel and if the Nurse Advice Line can be used out of state.
PHP	Nenahnezad Chapter House Fruitland, NM June 10, 2016	Put language on transportation benefits in the new Native American Member Guide. There was a suggestion for same day transportation for urgent care. Plan a collaborative meeting between Northern Navajo Medical Center and local Pres. Care Coordination team for discharge and case management.
UHC	Gallup, NM June 29, 2016	UHC went over what is new for 2016 for Value Added Services and Member Rewards. Many questions were asked about the "Care Card" and how to use it. The Ombudsman from UHC also presented at the meeting.
MHNM	Butterfly Healing Center Taos, NM July 7, 2016	Molina explained the differences between level 1, 2, and 3 of care coordination; Value Added Services and member rewards for pregnancy, diabetes, and information about the Peer Support Program.
BCBSNM	BCBS Headquarters Albuquerque, NM August 20, 2016	BCBS explained how a member could move from ABP to ABP Exempt if they have a medically frail condition. Also BCBS discussed some changes to the Centennial Rewards Program. Someone asked the difference between a level 2 and a level 3 care coordination which was explained to them.
PHP	Isleta Pueblo September 16, 2016	The question was asked if PHP does criminal background checks for home healthcare companies. The response yes, one is done by the home healthcare agency. If the member has concerns, bring it to the attention of the care coordinator. PHP explained how often a health assessment and comprehensive needs assessment is completed. There was a request for PHP to offer acupuncture as a value added service.
UHC	Dulce Community Center Dulce, NM September 26, 2016	The Vice President of the Jicarilla Apache Nation was present for the NAAB meeting. He expressed concern about substance abuse, PTST among veterans, and correctional system involvement with Tribal members. His administration would like to build strong partnerships and have UHC "come along side". There was discussion about ways the Tribe could be a transportation provider so that there is accessibility for members to get to their medical appointments.

MCO	Location/Date of Board Meeting	Issues/Recommendations
MHNM	Upper Fruitland Chapter House Upper Fruitland, New Mexico November 4, 2016	MHNM explained the importance of members completing their HRA and having a care coordinator. Molina explained their MyCD program – a six week peer led community based class for members with chronic conditions, to help them manage their condition and improve their health. Attendees asked about MyCD for PTSD and cancer. They were informed that MyCD is available for anyone with a chronic condition.
BCBSNM	Gallup Community Service Center Gallup, New Mexico November 9, 2016	There was one microphone shared by presenters. This made it difficult to present information in English then translated into Navajo. In the future BCBS will provide an adequate sound system with multiple microphones. Based on recommendation of attendees, BCBS plans to invite home healthcare agencies to future meetings.
UHC	Albuquerque Indian Center Albuquerque, New Mexico December 15, 2016	The Native American Advisory Board meeting was held at the Urban Indian Center in Albuquerque to provide benefits information to UHC members in this area of the community. UHC would like to partner with the center to find hard to reach members, complete HRAs, provide information to members, and arrange bus passes for those needing transportation.
PHP	Jicarilla Apache Area Dulce, New Mexico December 29, 2016	Presbyterian Health Plan sent out 33 invitations to its members for their Board meeting in Dulce. The meeting was rescheduled two times due to weather and other community events. No members attended this Native American Advisory Board meeting due to various reasons (weather, other events in community).

SECTION VII: QUALITY STRATEGY/HCBS ASSURANCES

Quality Strategy

Several quality initiatives continue to be performed and implemented the Centennial Care program, including Care Coordination, tracking of performance measures, critical incidents reporting and extensive MCO reporting and monitoring by HSD. Many of the quality strategy activities have been previously explained in other sections of this report.

- Please refer to Section II for updates on the care coordination audits that took place in 2015.
- Please refer to Section V. for information on service plan reductions audit.
- HSD continues to review high NF LOC and community benefit NF LOC denials on a quarterly basis to ensure the denials were appropriate and based on NF LOC criteria. No concerns were identified in 2016. Please see Section II for more information on NF LOC reviews and community benefit services reviews.
- Please refer to Section V for information on performance measure monitoring.
- Please refer to Section II for information on adverse incidents monitoring.

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. F. 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. F. for more information on HCBS service plan audits.

MCO Credentialing and/or Verification Policies

HSD manages provider enrollment for Agency-Based Community Benefit (ABCB) service providers. All interested providers are required to submit an initial application and annual recertification's to HSD to demonstrate that all required provider qualifications are met. HSD ensures that ABCB providers have the appropriate licensure/certification from the appropriate credentialing body. Once the provider is credentialed and approved by HSD, the MCOs are notified of the approval which allows the provider to enter into a contract for that approved service.

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. C. for the waiver year two 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: 2016 Value Added Services
Attachment C: 2017 Value Added Services
Attachment D: Behavioral Health Collaborative CEO Report
Attachment E: 2016 Consumer Satisfaction Survey Report
Attachment F: GeoAccess PH Summary
Attachment G: NM HSD Secret Shopper Survey Script
Attachment H: NM HSD Secret Shopper Survey Methodology
Attachment I: Figure 1 – Unreachable Member Campaign Progress Report
Attachment J: Figure 2 – Unreachable Member Campaign Performance Tracking
Attachment K: Key Utilization/Cost per Unit by Major Population Group