Centennial Care Waiver Demonstration

Section 1115 Quarterly Report
Demonstration Year: 1 (1/1/2014 – 12/31/2014)
Waiver Quarter: 4/2014

3/13/2015
Submitted by:
New Mexico Human Services Department

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Section I: Introduction

Program Goals

Prior to Centennial Care, New Mexico's Medicaid program served one-quarter of its citizens through a fragmented delivery system, operating under a myriad of federal waivers, administered by seven different managed care organizations (MCOs) and a fee-for-service (FFS) component. Medicaid accounts for nearly 20 percent of the State's total General Fund budget each year. In State Fiscal Year (SFY) 2012, New Mexico and the Federal government spent approximately four billion dollars on Medicaid services for New Mexicans. With the Governor's decision to expand Medicaid to newly eligibles beginning in January 2014, the State projected an addition of approximately 170,000 new enrollees to the program by June 2015. This projection has been exceeded with just over 190,000 recipients (Centennial Care and fee-for-service) in the expansion group as of January 2015. All of these factors, combined with rising program costs, necessitated modernization of the Medicaid program.

In June 2011, New Mexico began its ambitious plan to innovate its Medicaid program to accomplish the following goals:

- Assure that Medicaid recipients receive the right amount of care at the right time and in the most cost-effective or "right" setting.
- Ensure that the care being purchased by the program is measured in terms of its quality and not its quantity.
- Slow the growth rate of costs or "bend the cost curve" over time without cutting services, changing eligibility, or reducing provider rates.
- Streamline the Medicaid program.

In order to achieve these goals, the New Mexico Human Services Department (HSD) adopted four guiding principles:

- Develop a comprehensive service delivery system that provides the full array of benefits and services.
- Encourage more personal responsibility so that recipients become more active participants in their own health and more efficient users of the health care system.
- Increase the emphasis on payment reforms that pay for performance rather than for the quantity of service delivered.
- Simplify administration of the program for the State, for providers and for recipients.

The culmination is the development and implementation of Centennial Care, a comprehensive, integrated delivery system for Medicaid that integrates Physical Health (PH), Behavioral Health (BH), and Long-Term Care (LTC) services; ensures cost-effective care; and focuses on quality over quantity.

Key Dates

In August 2012, HSD submitted its Section 1115 demonstration waiver proposal to the Centers for Medicare & Medicaid Services (CMS) and released its competitive procurement to secure the MCOs that would administer the new integrated program. HSD received proposal submissions from bidders in November 2012 and awarded contracts to four MCOs in February 2013. In order to conduct a comprehensive readiness review process, the contracts were awarded almost a full year in advance of Centennial Care's commencement on January 1, 2014. The Centennial Care MCOs are:

- Blue Cross Blue Shield of New Mexico (BCBSNM).
- Molina Healthcare of New Mexico (MHNM).
- Presbyterian Health Plan (PHP).
- UnitedHealthcare (UHC).

In July 2013, CMS approved the Centennial Care 1115 demonstration waiver. Fundamental to the new program is a comprehensive care coordination system that requires coordination at a level appropriate to each member's needs. The robust care coordination system creates a person-centered environment in which members receive the care they need in the most efficient and appropriate manner. It requires:

- Assessing each member's physical, behavioral, functional and psychosocial needs.
- Identifying the medical, BH and LTC services and other social support services and assistance, such as housing and transportation.
- Ensuring timely access, coordination, and monitoring of services needed to help each member maintain or improve his or her physical and/or BH status or functional abilities while maximizing independence.
- Facilitating access to other social support services and assistance needed in order to promote each member's health, safety, and welfare.

The Centennial Care program was fully implemented on January 1, 2014.

Section II: Enrollment and Benefits

Enrollment

Centennial Care enrollment indicates a decrease for Temporary Assistance for Needy Families (TANF) and the 217-like Group and increases in all other populations. The expansion of Medicaid eligibility has contributed to the overall increase in enrollment. The majority of Centennial Care members are enrolled in Population 1-TANF and Related with Population 6-Group VIII (expansion) being the next largest group as reflected in Section III of this report.

Disenrollment

HSD continues to run the file for the short-term fix for the isolated disenrollment of Centennial Care members that was identified and addressed in the second quarter as validation to ensure that the long-term fix was successful. The isolated disenrollment was linked to the processing of the eligibility file between the Automated System Program and Eligibility Network (ASPEN) that determines eligibility and the Medicaid Management Information System (MMIS) that determines enrollment and disenrollment to Centennial Care. The short-term fix was implemented to ensure that members are not losing access to any services. The long-term fix to resolve these disenrollment issues was implemented in the fourth quarter. The disenrollment numbers have decreased in the fourth quarter.

Access

Throughout this report, unless otherwise noted, the most current monthly data is through November 2014. Quarterly data is available through the third quarter.

Primary Care Provider (PCP)-to-Member Ratio

The PCP-to-member ratio standard of 1:2000 was consistently met by all MCOs in urban, rural and frontier areas for all three quarters. For this reason, and to reduce administrative burden, the frequency of reporting was changed from monthly to quarterly. In September 2014, which was the last monthly report, the percent of open panels was as follows: BCBSNM – 91 percent, UHC – 96.7 percent, MHNM – 90.5 percent, and PHP – 83.3 percent.[1] PCPs can have up to 2,000 Medicaid members on their caseload. PHP has a capacity to serve 3.4 million members even though they only have 83.3 percent of open panels overall. There are no identified PCP concerns at this time.

Physical Health (PH) & Hospitals

Geographic access standards were met by all MCOs for general hospitals, PCPs, pharmacies and many specialties in urban, rural and frontier areas in the third quarter (see Attachment B – GeoAccess PH Summary). As compared to quarter two, BCBSNM

[1] PHP's number of open panels at the end of September was 1,724 (FYI - the number was 2,092 at the end of December).

improved its access in urban areas by meeting the standard for rheumatology, in rural areas for certified nurse midwives and transportation, and in frontier areas for assisted living facilities (ALFs). UHC showed improvement for transportation in both rural and frontier areas; the access standard was met in rural areas. MHNM met the standard in urban and rural areas for I/T/Us, urology and nursing facilities (NFs). MHNM improved access in frontier areas for hematology/oncology and neurosurgery as compared to quarter two; however, the access standard was not met. PHP improved access in urban areas for I/T/Us, in rural areas for neurology and rheumatology, and in frontier areas for endocrinology, rural health centers and neurology; however, the access standard was not met. Except for MHNM, in rural areas, MCOs met the standard for federally qualified health centers (FQHCs) in the third quarter.

A statewide access challenge continues for dermatologists, although MHNM was successful in meeting the access standard for dermatologists in urban and frontier areas. BCBSNM and MHNM did not meet the access standard in rural areas for hematology/oncology, and MHNM did not meet the access standard in frontier areas for the same. None of the MCOs met the standard for endocrinology and neurosurgery in rural and frontier areas. MHNM was the only MCO that met the access standard for rheumatology in both rural and frontier areas though the other MCOs are over 80 percent in frontier areas and improving in rural areas. In instances when specialty providers exist but are not contracted with a network, or are not willing to contract, an MCO will attempt to secure a single case agreement with the provider. When specialty providers are not available and a member's condition is medically necessary, arrangements are made for the member to see the closest provider. Transportation, meals, and lodging are coordinated and provided as necessary.

BCBSNM continues to use Strennus Network360® Market Analysis Report to identify available PH and LTC providers within New Mexico and in border areas. UHC is contracting with Covenant Medical Group, a large provider group in Texas with a New Mexico presence.

UHC is closing service delivery gaps with two distinct programs. The first initiative involves UHC collaboration with Lovelace Medical systems to deliver pulmonology services to critical care patients living in rural communities. Telemedicine physicians use secure connectivity and cutting-edge blue tooth stethoscope technology to provide comprehensive clinical care for patients living in remote access communities. A telemedicine clinic is starting with pulmonology patients in Roswell and will expand to other remote locations and additional sub-specialties.

UHC is also introducing tele-dermatology consultations using asynchronous telemedicine. Collaboration between contracted dermatologists and FQHCs will target patients in Northwest and Southeastern New Mexico and will expand to other rural and frontier counties.

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

Behavioral Health (BH)

In HSD's pursuit of increasing access to services through expansion of workforce capacity, the Behavioral Health Services Division (BHSD) in collaboration with the Medical Assistance Division (MAD) is finalizing the details of a Supervisory Protocol. The Supervisory Protocol builds on a preexisting document and process that existed with the former Single State Entity. It is intended to broaden which types of agencies can apply to have services delivered by mid-level practitioners including, but not limited to; mental health counselors, social workers, interns within those same fields of expertise, and other BH provisional licensures as identified by the State-boards that license clinicians within BH.

The Supervisory Protocol outlines expectations for providing comprehensive clinical supervision that includes components of a quality service review (QSR) model for improving clinical practice in general. As of fall 2014, BHSD launched the clinical supervision mini grants and awarded 13 grantees an allocation between $25,000 and $50,000 to implement the model. The work with these grantees is serving to build knowledge about successful strategies, identify barriers, and build resources respectively. It is contributing to the formulation of how to fill gaps in the network for improving system delivery and access to services in general by expanding the workforce. The Supervisory Protocol is in its final stages of development and is anticipated to be released in draft form within the next quarter.

In establishing the details of the Supervisory Protocol, there have been meetings with licensing boards to understand how current regulation is supporting or hindering the supervision model. Both the counseling and social work boards are making changes to have broader allowances around use of telehealth, reciprocity, and supervision. BHSD continues to draw on existing agreements with the University of New Mexico (UNM) Division of Community Behavioral Health (CBH) for participation in meetings and conferences. The main concern with the protocol is how best to allow for clinical practice of mid-level professionals while still ensuring appropriate supervision practices.

Efforts are being made to meet the BH GeoAccess service standards in the rural and frontier areas of the state. Please see Attachment C – GeoAccess BH Summary for additional information on BH access for the third quarter of 2014.

Long-Term Care (LTC)

All MCOs met the access standard for both delegated and directed personal care service (PCS) agencies in urban areas. As of quarter three, BCBSNM met the standard for assisted living facilities (ALFs) in frontier areas, and MHNM met the standard for nursing facilities (NFs) in urban and rural areas.

None of the MCOs met the established standard for ALFs in rural areas, but there was some improvement reported by BCBSNM and MHNM compared to second quarter data. PHP did not meet the standard in urban areas for ALFs, and MHNM did not meet the standard in frontier areas. It is important to note that in the GeoAccess calculation methodology all members are included in the member-to-provider ratios, though not all members will require ALF services. There is not a high utilization of ALF services, and the network is sufficient to meet the needs of the members requesting services. HSD continues to work with the MCOs regarding options to encourage providers in all regions to join the pool of Medicaid-enrolled providers.

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

Transportation

BCBSNM and UHC contract with Logisticare for non-emergency transportation, and both met the access standard for urban and rural areas in the third quarter. UHC did not meet the standard in frontier areas. While geographical access to transportation improved for these MCOs, reports of complaints and grievances against Logisticare have been numerous (see Section XII – Consumer Issues). Multi-faceted internal action plans were developed by BCBSNM and UHC to resolve the grievances (see Attachment D – MCO Action Plans); however, complaints continued to increase in October and November 2014. HSD is working with BCBSNM and UHC to identify causal factors and to set goals and establish timelines for improvement.

Service Delivery

Pharmacy

The overall number of claim denials for both formulary and non-formulary drugs was also high (see Table 1.). HSD requested that each MCO explain the high volume of claim denials. HSD will analyze and evaluate all MCO responses regarding the volume of claim denials prior to giving direction to the MCOs.

Table 1. Pharmacy Claim Denials, November 2014

	Formulary Claim Denials	Non-Formulary Claim Denials
BCBS	8,982	12,553
MHNM	45,338	15,349
PHP	30,234	4,672
UHC	24,965	20,673
Total	109,519	53,243

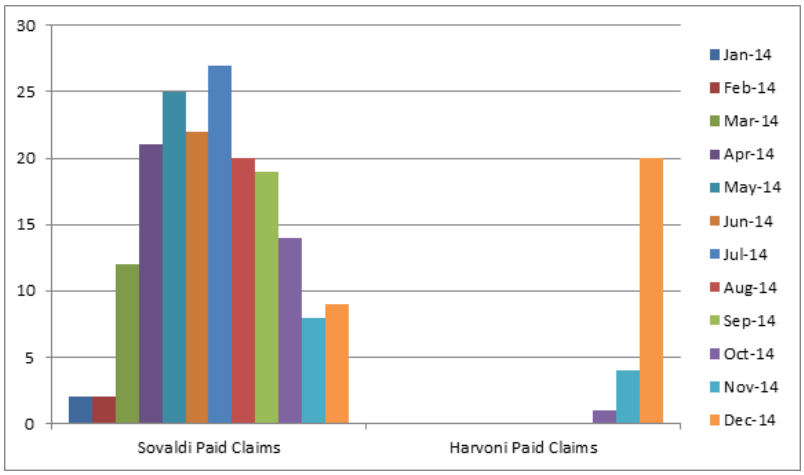
Source: November 2014 MCO Reports # 44

As reported last quarter, HSD requested involvement in the MCOs' Pharmacy and Therapeutics (P and T) Committees. PHP agreed to have HSD participate in its P and T meeting as an invited guest. The other MCOs agreed to meet with HSD subsequent to their internal P and T meetings. Concerns regarding formulary deletions, prior authorization requirements and claim denials will be addressed. If HSD determines that Centennial Care members are being negatively impacted, HSD will direct the MCOs to evaluate and adopt new pharmaceuticals based on clinical and economic value and ensure member access and provider reimbursement.

BCBSNM stated in its pharmacy report analysis that the key driver in its significant increase of claims and total pharmacy spend, is the increased utilization of high-cost specialty pharmacy products, including products to treat hepatitis C and oncology diagnoses. BCBSNM uses prior authorization, quantity limitations, channel management and care coordination to ensure the appropriate utilization of these agents.

As an example of rapid changes in utilization, BCBSNM provided the following analysis regarding Harvoni® and Sovaldi® utilization. "Harvoni®, introduced in October 2014, has become the most utilized therapy in the treatment of hepatitis C for BCBSNM members. This represents a significant shift away from Sovaldi®, which was introduced to the market in 2013. Because Harvoni® is a simpler treatment regimen, with an improved cure rate and fewer side effects, this shift in utilization is not surprising, but the rapidity of the shift is striking." HSD continues to closely monitor utilization of products to treat hepatitis C.

Figure 2. BCBSNM Harvoni® and Sovaldi® Utilization (2014)



Source: BCBSNM Analysis, November 2014 Report # 44

Nursing Facilities

In September 2014, HSD was notified by the Department of Health (DOH), Division of Health Improvement (DHI), that it was terminating the Medicare provider agreement for a nursing facility in southern New Mexico due to survey outcomes. The nursing facility served 29 Medicaid eligible residents. A new company purchased the building and is in the process of becoming a certified Medicaid facility. HSD directed the applicable MCO (based on member enrollment), to transition Medicaid members to other Medicaid/Medicare certified facilities in the area. Educational meetings were conducted with the residents and their families regarding member options. The residents were informed that if they decided to stay, they would lose their institutional Medicaid coverage. By the end of November 2014, 12 residents safely transferred to neighboring nursing facilities, two went home, and the remaining chose to stay in the facility. The remaining residents worked out alternative payment arrangements directly with the nursing home provider. HSD is available to assist these remaining residents with Medicaid eligibility should the facility become certified in the future.

Durable Medical Equipment (DME)

A concern regarding high utilization of adult diapers/incontinent supplies, oxygen, and enteral feedings was addressed. MHNM is in the process of identifying high utilization members as well as DME providers to determine if it will be necessary to establish approval limits for each of the products identified. PHP reported high utilization of oxygen/supplies, respiratory equipment such as nebulizers, wheelchairs and incontinence supplies. PHP expects these DME items to continue to have high volume utilization for the Medicaid population. UHC also has high oxygen/supplies utilization, which it attributes to the high elevation of New Mexico and to respiratory disease. UHC has had an increase in wheelchair utilization and hospital bed needs in its population. In

the first quarter of 2015, HSD will request that the MCOs identify how each is monitoring and preventing stockpiling of goods such as diapers.

School-Based Health Centers

In the fourth quarter, the MCOs implemented the new School-Based Health Center (SBHC) site review tool that was created by HSD and DOH Office of School and Adolescent Health (OSAH). After conducting several SBHC site reviews using the new tool, the MCOs have been able to contribute valuable feedback on how the tool may be fine-tuned so that future site reviews are even more successful. HSD and DOH will continue to make improvements to the tool.

Provider Network

Provider-to-member ratios remain stable in the third quarter with some improvements as detailed in the GeoAccess summary. MCOs are all well within provider-to-member ratios and continue their efforts in adding new providers. Terminations are within normal attrition ranges, and new providers exceeded terminations in almost all cases. Single case agreements remained low throughout the quarter with the exception of BCBSNM for physical health with 126 agreements listed (an increase of 61 percent from the second quarter). The majority of these providers were out-of-state. BCBSNM actively engages and attempts to contract with in-state and border providers.

The frequency of the Provider Suspension and Termination report has been changed from quarterly to semi-annual. The first semi-annual report is due from the MCOs in January 2015.

Amendments

A second amendment to each MCO contract was signed by all applicable parties (see Attachment F – Centennial Care Contract Amendment #2). A third amendment was drafted and presented to the MCOs during the fourth quarter.

Centennial Rewards Program

The Centennial Rewards program continued to grow during quarter four, engaging significantly more members during this period. As of December 2014, over 263,000 distinct members had earned rewards and nearly 47,000 had registered for the program. While any Centennial Care enrollee can earn points by engaging in one of the "healthy behaviors", registration is required for point redemption.

Members had earned a total of $9.6 million in Centennial Rewards points and had redeemed roughly $800,000. While this ratio of dollars earned to dollars redeemed is still low at 8.1 percent, it is much higher than it had been for earlier quarters and the increase has been steady through the period. This is largely attributable to continued and increasing efforts in member education, outreach and engagement.

Community Interveners

Community Outreach Program for the Deaf (COPD), the community intervener subcontractor for the Centennial Care MCOs, receives $300,000 annually for community intervener services from the New Mexico Legislature. This funding is allocated to the New Mexico Commission for the Deaf and Hard of Hearing which, in turn, contracts with COPD. Services that are not reimbursed through the Centennial Care program are billed against that contract. The ability to have some services reimbursed by Medicaid has helped the agency to provide services to members who might not otherwise have received them.

COPD provided a total of 338 units of community intervener support services billed under Medicaid. This totaled $2,155.50 in claims for the third quarter. COPD reported that they began billing the Centennial Care MCOs in September 2014; therefore, the claims are somewhat low for the third quarter. HSD continues to direct the MCOs to provide outreach and training to their care coordination staff in order to identify members who are eligible for the community intervener services.

Section III: Enrollment Counts

The following table outlines all enrollment activity under the demonstration. The enrollment counts are unique enrollee counts, not member months. Please note that these numbers reflect current enrollment in each Medicaid Eligibility Group (MEG). If members switched MEGs during the quarter, they were counted in the MEG that they were enrolled in at the end of the reporting quarter.

Members change eligibility and thus MEGs during the year. In order to provide an unduplicated count for the quarter and YTD numbers reflect the last month a member was in the MEG within the period.

Table 3. Enrollment Counts for Q4

Demonstration Population	Total # Demonstration Participants Quarter 4 Ending – 12/14	Current Enrollees (Year to Date)
Population 1 – TANF and Related	370,934	375,379
Population 2 – SSI and Related – Medicaid Only	41,808	41,829
Population 3 – SSI and Related – Dual	36,307	39,114
Population 4 – 217-like Group – Medicaid Only	225	278
Population 5 – 217-like Group - Dual	2,290	2,732
Population 6 – VIII Group (expansion)	203,443	236,707
Totals	655,007	696,039

Disenrolled is defined as when a member was in Centennial Care at some point in the prior quarter and disenrolled at some point during that quarter or in the reporting quarter and not re-enrolled at any point in the reporting quarter. Members who switch MEGs are not counted as disenrolled.

Table 4. Disenrollment Counts for Q4

Disenrollments	From Q3 to Q4			Total Disenrollments During Q4
Month that member was disenrolled	**01-Aug-14**	**01-Sep-14**	**01-Oct-14**	
Population 1 – TANF and Related	3,601	3,730	4,053	11,384
Population 2 – SSI and Related – Medicaid Only	259	317	253	829
Population 3 – SSI and Related – Dual	356	270	256	882
Population 4 – 217-like Group – Medicaid Only	11	29	8	48
Population 5 – 217-like Group – Dual	21	28	15	64
Population 6 – VIII Group (expansion)	2,655	2,592	2,653	7,900
Total				**21,647**

Section IV: Outreach

In the fourth quarter, HSD continued the YESNM-PE system demos that were started in the last reporting quarter. These voluntary demonstration sessions were held the first and third Friday of each month. The YESNM-PE demo sessions train presumptive eligibility determiners (PEDs) to use YESNM-PE for screening of potential enrollees and assist them with applying for Medicaid benefits.

MAD also continued to hold PED certification webinars for qualified individuals to become PED certified, for existing PEDs who wished to have a refresher course, and for PEDs in need of recertification. In this quarter, 28 PED certification sessions were held with approximately 534 attendees. (Note: NM currently has 707 active PEDs state-wide).

In the fourth quarter, the number of applications submitted increased to over 1,200 while the individual number of PEs granted and individuals who applied and were approved for ongoing coverage increased substantially. In many cases, applications were for more than one individual.

Table 5. YESNM-PE Statistics	**Q4**
Total # of PEDs Who Utilized YESNM-PE	208
Total Applications Received Through YESNM-PE	3,625
Total # of Individuals Who Applied for Ongoing Medicaid Benefits	5,008
Individuals Approved for Ongoing Coverage	4,014
Individuals Denied	514
Individuals Pending	480
Total # of PEs granted	887

Section V: Collection and Verification of Encounter Data and Enrollment Data

All four MCOs are in production for all invoice types, professional, institutional, and dental. The MCOs continue to submit encounters daily and/or weekly and are current with their encounter submissions with the exception of some encounters being held for providers who are not yet enrolled with Medicaid. The MCOs have been working with these providers and directing them to the Medicaid web portal to become enrolled. Once the provider is enrolled and an active Medicaid provider, the MCOs submit any encounters being held.

Reporting tools to track the timeliness and accuracy of Centennial Care encounters were developed to ensure that encounters are monitored on a regular basis in accordance with the contract. HSD is continuing to develop a report for the MCOs to submit that will reflect the claims detail around timeliness and accurateness. This report will ultimately ensure completeness of encounters. A dashboard tool will be created for HSD management to review and compare MCO encounter submissions.

Data is extracted on a continual basis to identify Centennial Care enrollment by MCO and for different populations. Any discrepancies that are identified, whether due to systematic or manual error, are immediately addressed. Eligibility and enrollment reports were developed and are run on a regular basis to ensure consistency and tracking of numbers. HSD continues to monitor enrollment and any anomalies that may arise so that they may be addressed and resolved.

Section VI: Operational/Policy/Systems/Fiscal Development Issues

Program Development

MCO Assigned PCPs and Member Change Requests

BCBSNM completed its action plan on October 1, 2014 to restrict auto-assigning members to a PCP until the sixteenth business day after enrollment. UHC completed a similar action plan on October 18, 2014. HSD will verify contractual compliance in this area by reviewing the number of auto-assigned members to PCPs as reported in the first quarterly submission of the PCP Report in 2015.

Care Coordination

The MCOs are required to report their efforts to locate members in need of completing the health risk assessment (HRA) and comprehensive needs assessment (CNA). Efforts have included more face-to-face visits, claim reviews, and engagement of patient-centered medical homes (PCMHs), PCPs, and community partners to assist with locating members. HSD monitors and tracks weekly and monthly progress by MCO (see Table 6, Unreachable Member Campaign). Members have not lost eligibility as a result of being unreachable.

The MCOs' ongoing unreachable member campaigns have proven successful. In November, HSD and the MCOs collaborated in further refining the monthly reporting template. In only one instance did an MCO not reach its monthly target. HSD is working with BCBSNM to identify additional strategies to ensure that it reaches its established goals.

Table 6. Unreachable Member Campaign

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

Source: MCO monthly reporting

HSD recently conducted an on-site audit of care coordination activities as a follow-up to its desk audit in July 2014. During the on-site audit, which took place from December 15 to December 18, 2014, it was evident that the MCOs had made improvements and had implemented some of the best practices recommended by HSD. However, HSD continues to identify areas in need of improvement. The final audit reports will be available during the first quarter of 2015 and will contain action plans specific to each MCO, which HSD will continue to monitor.

HSD's Care Coordination Unit continues to provide education and training to internal and external stakeholders regarding the importance of care coordination. A recent training was held for all personal care service providers regarding care coordination and its relevance to members receiving those services.

Electronic Visit Verification (EVV)

HSD continues to evaluate the progress and milestones reached regarding EVV implementation and will determine a complete "go live" date for all Centennial Care LTC providers. The full implementation of EVV continues to be challenging as HSD, the MCOs, and First Data continue to work through implementation phases of the pilot. HSD monitors progress and attends two weekly conference calls with the MCOs and the providers.

The EVV Governance Committee meets weekly and the project lead informs the committee of progress and outstanding challenges and other items of discussion. HSD provides technical assistance regarding billing, authorizations, and all other challenges identified by the pilot providers.

Health Plan Contract Compliance and Financial Performance Relevant to the Demonstration

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

Fiscal Issues

HSD has completed the re-processing of capitations for the period January to June 2014. HSD is establishing guidelines and processes to automate the reconciliation of capitation payments in a timely manner. These reconciliations include retroactive eligibility changes, including Medicare eligibility and SSI eligibility, and aligning with date-of-death data.

Systems Issues

There have been nursing facility level of care (NF LOC) and setting of care (SOC) issues that have impacted all four MCOs. These issues were due to utilizing new interfaces among multiple systems. HSD receives NF LOC information from the MCOs through two separate interfaces that are used to update the NF LOC and SOC information in the MMIS for MAD and the NF LOC in ASPEN for the Income Support Division (ISD). It was first assumed that updates to one system would lead to updates in the other system. The NF LOC information is not exchanged through an interface between the MMIS and ASPEN. HSD has determined that additional training and technical assistance is necessary so that there is better understanding of the distinctions between the interfaces.

HSD has directed the MCOs to have both clinical and systems staff at system meetings to ensure that all appropriate staff receives the same information. HSD is in the process of training staff who coordinate with the MCOs on NF LOC issues so that they understand the process. One of the issues identified related to the NF LOC not updating in ASPEN is attributed to an error report that is not being generated by ASPEN. Until a systematic error report can be developed for the ASPEN interface, HSD will implement a manual error report to provide to the MCOs. Additionally, HSD has established a dedicated eligibility unit that will process applications for institutional care category.

HSD also identified an issue with patient pay amount differences between the MMIS and ASPEN. HSD has conducted significant research and analysis regarding this issue and identified that not all patient pay amounts are being sent from the eligibility system, ASPEN to the MMIS. The system fix was implemented in the fourth quarter and will resolve patient liability amount discrepancies prospectively. The next step in the process is to work to identify and resolve any patient pay discrepancies that existed prior to the fix.

The system fixes for the eligibility issues impacting disenrollment that are addressed in Section II were implemented in the fourth quarter. HSD is continuing to run the file that was utilized for the short-term fix to ensure the long-term fix is successful.

Section VII: Home and Community Based Services (HCBS)

New Mexico Independent Consumer Support System (NMICSS)

The NMICSS continues to recruit and establish a system of organizations that provide standardized information to beneficiaries about Centennial Care, long-term services and supports (LTSS), the MCO grievances and appeals process, and the fair hearing process.

The NMICSS reporting for the fourth quarter is provided by the Aging and Long-Term Services Department (ALTSD) Aging and Disability Resource Center (ADRC). The ADRC is the single point of entry for older adults, people with disabilities, their families, and the general public to access a variety of services, including state and federal benefits, adult protective services (APS), prescription drugs, in-home and community-based care, housing, and caregiver support. The ADRC provides telephonic information, assistance, referrals and advocacy in those areas of daily living that will maximize personal choice and independence for seniors and adults with disabilities throughout New Mexico, as well as for their caregivers.

ADRC coordinators provide over the phone counseling in care coordination. ADRC staff offers options, coordinates New Mexico's aging and disability service systems, provides objective information and assistance, and empowers people to make informed decisions. The ALTSD provides quarterly reports to HSD; the ADRC Caller Profile Report and the Care Transitions Program Report.

The numbers below reflect calls made to the ADRC hotline from October 1 to December 31, 2014.

Table 7. ADRC Call Profiler Report

Topic	# of Calls
Home/Community Based Care Waiver Programs	995
Long Term Care/Case Management	114
Medicaid Appeals/Complaints	67
Personal Care	18
Transitional Case/Care Management	184
State Medicaid Managed Care Enrollment Programs	211
Medicaid Information/Counseling	1134

Listed below are examples of the nature of the calls the ADRC receives by topic**:**

Home/Community Based Care Waiver Programs

- Centennial Care waiver community benefit registry.
- Requests for expedited registry.
- LTSS information and available options.

- Assistance and counseling for community reintegration.
- Assist NF staff with patient transitions.
- Referrals to ADRC care transition team.
- Referrals for Centennial Care options counseling.
- Referrals to LTC ombudsman.

Long-Term Case/Care Management

- Provide assistance and referral to programs that assist in planning and arranging for services.
- Provide counseling and assistance with LTC plans.
- Assist with education and referrals to NF care.

Medicaid Appeals/Complaints

- Assist with understanding Centennial Care grievance and appeals process.
- Referrals to MCOs for filing grievance and appeals.
- Referrals to advocacy organizations and legal services for fair hearings with HSD.
- Referrals to the LTC ombudsman.

Personal Care

- Education and referrals for personal care services (PCS).
- Education and assistance in understanding activities of daily living (ADLs).

Transitional Case/Care Management

- Assist with transitions from hospitalization to independent living.
- Assistance to obtain and coordinate the support services needed during transition.

Medicaid Information/Counseling

- Programs that offer information and guidance for people who may qualify for Medicaid.
- Information about the eligibility requirements for Medicaid and how to apply.
- Questions about Medicaid services available to individuals with disabilities.

Medicaid Managed Care Enrollment

- Medicaid managed care options, including benefits covered (and not covered) by the program.

The numbers below reflect counseling services provided by the ALTSD Care Transition Program from October 1 to December 31, 2014.

Table 8. ADRC Care Transition Program Report

Counseling Services	# of hours	# of Nursing Home Residents	# of Contacts
Transition Advocacy Support Services		101	
Medicaid Education/Outreach	845		
*Medicaid Options/Enrollment	96		
Pre/Post Transition Follow-up Contact			**1159

*The care transition specialist team educates residents, surrogate decision makers and facility staff about Medicaid options available to the resident and assisted with enrollment.

** Note: 78 percent of the contacts are pre-transition contacts and the remaining 22 percent are post transition contacts. These numbers are resident specific and situation dependent.

The ALTSD Care Transition Bureau (CTB) is actively engaged in other activities related to the NMICSS. The CTB is providing Medicaid beneficiaries enrolled in Centennial Care receiving LTSS (institutional, residential and community based) assistance to navigate and access covered healthcare services and supports. CTB staff serve as advocates and assist individuals in linking to both long-term and short-term services and resources within the Medicaid system and outside of the system. CTB staff also monitors to ensure that services identified as a need are provided by the MCOs, their subcontractors and community provider agencies. Their main purpose is to help consumers identify and understand their needs and to assist them in making informed decisions about appropriate LTSS choices in the context of their personal needs, preferences, values and individual circumstances. The CTB has assisted 157 individuals during the fourth quarter.

Critical Incidents

The HSD behavioral health critical incident report protocol was released in November 2014. The Critical Incident Reporting (CIR) workgroup is making preparations for state-wide provider training. The training discussions have been thorough and comprehensive with the group working diligently to ensure that training does not pose an additional administrative burden. The CIR workgroup has expanded its membership to include representatives from other BH divisions at the state level including Children, Youth, and Families Division, and the Licensing and Certification Authority. Consulting with APS to determine if additional cross-walk activities need to occur to ensure consistency in service delivery and reporting across all parts of the system is being considered. HSD is continuing to monitor the system through the reports received as to provider compliance and any needed system changes.

Critical incidents are now being reported quarterly as opposed to monthly by each MCO. This data is trended and analyzed by HSD.

The HSD Critical Incidents (CI) Unit engaged in the following monitoring activities during the fourth quarter with respect to the performance oversight of the MCOs and their provider agencies:

- Bi-weekly CIR workgroup meetings continued to be held between MCOs and HSD to discuss issues and concerns about the critical incidents reporting process. Clarification of the requirement to report within 24 hours and reduction of duplicate reporting were also addressed.

- Opportunities for future systems improvements and ensuring that members with BH challenges receive the services needed to successfully maintain health and safety were discussed by the workgroup. Each MCO shares incidents with their internal BH unit for review and appropriate follow-up. Internal as well as external resources have also been discussed for BH recipients. BH provider training sessions are planned for 2015 and will include identifying training supports for caregivers who work with members who live with mental illness in an effort to continue to enhance the delivery of HCBS and outcomes for these members.
- High utilization of Emergency Room (ER) has also been a topic discussed in the workgroup. Each MCO has an internal process in place to address this issue. The overall goal is to reduce the unnecessary visits to the ER when the visit is for reasons that could have been addressed by a primary care physician or urgent care.
- Internal collaborations continue to occur between the HSD CI Unit and other internal HSD/MAD staff. The HSD CI Unit shares relevant information with other state agencies when a system issue is identified. A discussion was initiated with representatives from ALTSD regarding the duplication of reports received via fax, phone, email, or website and possibilities for reduction of these duplications.
- Daily review of incident reports is conducted by the MCOs and HSD CI unit. Quality of reporting by providers and the documentation of follow-up by the MCOs has shown improvement. UHC implemented an action plan that included a process improvement project utilizing a new work plan based on technical assistance and feedback from HSD staff. UHC now holds twice weekly meetings to review their CI dashboard and the UHC CI Team meetings were increased from bi-monthly to weekly in mid-September to monitor progress on each internal action item in the work plan. UHC's Vice President of Quality Management has tasked the UHC quality compliance manager with further supporting oversight of the day-to-day performance of CI staff. This represents a permanent change to the organizational structure of the UHC CI Team. UHC has also revised its CI policy with feedback from the HSD CI unit which now includes random internal quality spot checks by UHC's quality manager and enhanced standard operating procedures (SOP) to require use of the tickler system created in UHC's database. UHC holds regular case review meetings between the medical directors and CI RNs. HSD's routine review of CI reports from UHC for errors in reporting of demographical information, duplicated reports, reports of non-reportable events (escalation of care, fall/no EMS) and untimely reporting have

all decreased. HSD conducted an on-site visit in December 2014 with UHC Quality staff including their CI team to observe a demonstration of UHC's improved internal processes for CI reporting. Based on the improved processes demonstrated by UHC and the improved quality and accuracy in UHC's daily reporting seen by HSD through daily quality reviews of CI reports; HSD is moving forward with a final resolution of UHC's CI action plan.

Each quarter, a review of all deaths submitted through the HSD critical incident web portal is conducted. HSD clinical staff reviews decedent data and consults on mortality cases and complex cases.

In the fourth quarter, there were a total of 306 reported deaths: 275 were expected deaths, 30 were unexpected and one was a suicide. The suicide did not occur during authorized services hours or while the member was in a facility. This case is still open and under review by the MCO.

Of the remaining 30 unexpected deaths, eight cases have been investigated and closed by the MCO as no further actions required. Sixteen cases are still open and under review by the MCO. These cases are also being investigated by the police or the Office of the Medical Investigator. Six unexpected deaths occurred during authorized service hours; three of these cases have been investigated by the MCO and are now closed. No further action is necessary. All three cases occurred in nursing home facilities. The remaining three cases are still under review pending further information; two cases occurred at the member's personal residences and one occurred in a group home. Of the six deaths occurring during authorized service hours, none raised concern about the care or services provided to the recipient.

Eighteen cases of elopement-missing occurred: six cases were reported by the home health agencies providing HCBS and involved members aged 40-86 who were reported as missing by their families, or were not found at the time that services were to be provided. The 86 year old member was found wandering and lost and was safely returned to his home. Two cases were reported by residential treatment centers and involved 17 year old members. One member was reported missing after not returning from a "pass" to home and is still missing, but the member is in phone contact with his parents. The other member left the facility without permission and has been returned to the facility. Two cases were reported by a treatment foster care program and involved recipients aged 16 and 18. The 16 year old left a counseling session without permission and law enforcement was notified. The recipient was found and is now in juvenile detention. The 18 year old left a group home without permission and law enforcement was notified. The member is now with a potential guardian and is continuing to receive BH services. Five cases were reported by a group home and involved recipients aged 14-62. Three members left the home without permission and were gone overnight. Law

enforcement was notified. All three members are back in the home and are safe. Two members (aged 14 and aged 86) left the home without permission and are still missing. Law enforcement has been notified. Three cases were filed by the MCO as reported to the care coordinator and involved recipients aged 31-61. The 61 year old member was reported missing by family and has been found and returned home. The 46 year old member was reported missing from an unlicensed group home by the family and is still missing. Law enforcement has been notified. The 31 year old recipient has been reported as homeless and the MCO has not located him.

In the quarter, the web-based system supported over 2,313 users statewide. The database managed more than 2,607 reports with 1,608 monitored for follow-up.

Table 9. Critical Incident Types

Critical Incident Types	Centennial Care		Behavioral Health		Self-Directed	
	#	%	#	%	#	%
Abuse	188	7%	58	28%	9	6%
Death	306	12%	3	1%	20	14%
Natural/Expected	275	11%	2	1%	19	13%
Unexpected	30	1%	1	0%	1	1%
Homicide	0	0%	0	0%	0	0%
Suicide	1	0%	0	0%	0	0%
Elopement-Missing	18	1%	10	5%	0	0%
Emergency Services	1578	61%	96	47%	88	63%
Environmental Hazard	46	2%	1	0%	2	1%
Exploitation	156	6%	2	1%	13	9%
Law Enforcement	113	4%	25	12%	4	3%
Neglect	202	8%	11	5%	4	3%
Total	**2607**		**206**		**140**	

Per CMS's request, HSD has further broken out critical incidents by MCO and also included the non-Centennial Care (fee-for-service) data in the table below.

Table 10. Critical Incidents by MCO

Centennial Care										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		FFS/HSD	
	#	%	#	%	#	%	#	%	#	%
Abuse	13	4%	44	6%	53	13%	78	7%	0	0%
Death	68	19%	92	12%	47	12%	98	9%	1	50%
Elopement Missing	2	1%	4	1%	6	2%	6	1%	0	0%
Emergency Services	215	61%	501	65%	208	53%	654	60%	0	0%
Environmental	2	1%	11	1%	10	3%	23	2%	0	0%
Exploitation	17	5%	40	5%	16	4%	83	8%	0	0%
Law Enforcement	20	6%	37	5%	17	4%	39	4%	0	0%
Neglect	17	5%	40	5%	39	10%	105	10%	1	50%
Total	354		769		396		1086		2	

Behavioral Health										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		FFS/HSD	
	#	%	#	%	#	%	#	%	#	%
Abuse	6	15%	12	23%	33	44%	7	18%	0	0%
Death	1	3%	2	4%	0	0%	0	0%	0	0%
Elopement Missing	2	5%	2	4%	5	7%	1	3%	0	0%
Emergency Services	20	51%	28	53%	25	33%	23	61%	0	0%
Environmental	0	0%	0	0%	1	1%	0	0%	0	0%
Exploitation	0	0%	0	0%	1	1%	1	3%	0	0%
Law Enforcement	8	20%	7	13%	6	8%	4	11%	0	0%
Neglect	2	5%	2	4%	4	5%	2	5%	1	100%
Total	39		53		75		38		1	

Self Directed										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		FFS/HSD	
	#	%	#	%	#	%	#	%	#	%
Abuse	3	10%	2	6%	0	0%	4	8%	0	0%
Death	3	10%	4	12%	3	43%	10	14%	0	0%
Elopement Missing	0	0%	0	0%	0	0%	0	0%	0	0%
Emergency Services	18	60%	22	65%	4	57%	44	64%	0	0%
Environmental	0	0%	0	0%	0	0%	2	3%	0	0%
Exploitation	3	10%	4	12%	0	0%	6	9%	0	0%
Law Enforcement	2	7%	1	3%	0	0%	1	1%	0	0%
Neglect	1	3%	1	3%	0	0%	2	3%	0	0%
Total	30		34		7		69		0	

Community Benefit

Participant-Centered Planning and Service Delivery

As a result of comments made at the legislative hearing in November 2014, Medicaid Director Julie Weinberg worked with the ICSS project lead to schedule three "listening sessions" to provide an opportunity for members and/or advocates to voice their concerns. Sessions were held in Farmington (Northern New Mexico), Las Cruces (Southern New Mexico) and Albuquerque (Central New Mexico). One session was conducted per week in the first three weeks of December 2014. The sessions provided an opportunity for HSD staff, along with leadership from all four MCOs, to listen to various issues affecting self-directed community benefit (SDCB) members.

Three main issues were identified during the listening sessions. The first issue identified SDCB members who experienced budget reductions. The specific members' cases are being reviewed by HSD staff and policy adjustments may be needed to rectify some of the issues. The second issue was related to member transitions from ABCB to SDCB and the lengthy process involved. The third issue is related to a service previously covered in the Mi Via waiver, community direct support/navigation, which is no longer a service in the Centennial Care waiver. All of the issues are being researched and HSD will provide follow-up information in its annual Centennial Care report.

Self-Directed Community Benefit

SDCB Report #4 revisions that were made during the second quarter have been successfully implemented into the FOCoS system. FOCoS staff provided a WebEx/GoTo meeting and training that was attended by many care coordinators and other staff from each MCO. An electronic version of the training has been made available for future reference.

Early in the demonstration, HSD identified issues that contributed to the delay of some annual care plans. The delays affected approximately 50 out of 1000 (five percent) total members receiving SDCB services. HSD immediately responded by facilitating follow-up trainings on the SDCB and applicable systems. HSD also held weekly calls with MCOs and the financial management agency (FMA), Xerox, to ensure that the issues were corrected. Currently, there are few, if any, delays in care plan development. Should they occur, HSD, the applicable MCO, and the FMA immediately collaborate to resolve issues to ensure continuity of care for the member.

A small population of SDCB members who transitioned from the prior Mi Via waiver without an employer of record (EOR), may still not have an EOR. In Mi Via, prior to Centennial Care, SDCB member records were not required to have an EOR if the Mi Via member only used vendors for services rather than individual employees. Now, in Centennial Care SDCB, the policy manual includes a requirement for all members to have an appropriate EOR on record with the FMA, Xerox. The SDCB manager requested that Xerox provide each MCO with a report of the number of SDCB members who currently do not have an EOR. HSD requires each MCO to ensure that all of its SDCB members obtain a qualified EOR.

Section VIII: AI/AN Reporting

Access to Care

Please see Section II of this report for information related to access to care.

Contracting Between MCOs and I/T/U Providers

In the fourth quarter, the MCOs have had little success in formally contracting with additional I/T/Us but treat all I/T/Us as participating providers in their network. I/T/Us are not required to contract with the MCOs for services.

Ensuring Timely Payment for All I/T/U Providers

All four MCOs reported 98.5 percent or better claims accuracy to I/T/U providers in the last quarter.

Issues Identified and Recommendations Made by the Native American Advisory Board (NAAB) and the Native American Technical Advisory Committee (NATAC)

The last NATAC meeting was held on November 10, 2014. As discussed at the meeting, HSD will request that the MCOs add NATAC members and I/T/Us to their NAAB meeting invites. One NATAC member requested that the MCOs send letters to their members to inform them of upcoming meetings or health fairs in their respective geographical areas.

Table 11. Fourth Quarter NAAB Meetings

MCO	Date of Board Meeting	Recommendations
BCBS	11/11/14	Provide teleconference capabilities at the meetings. Letters will be sent out to invite members (rather than post cards). BCBS will share meeting information with their care coordinators and customer service representatives.
MHNM	10/28/14	Group wanted a future meeting in the same area. There were recommendations for behavioral health services and a parenting program.
PHP	12/19/14	MCOs should contract with Tribes, community health representatives (CHRs) and IHS to complete HRAs.
UHC	12/04/2014	Focus on opportunities to include cultural interventions in behavioral health services. Integrate telemedicine where possible.

Section IX: Action Plans for Addressing any Issues Identified

Please see Attachment D – MCO Action Plans.

Section X: Financial/Budget Neutrality Development/Issues

HSD has successfully completed capitation rate development for the second year of Centennial Care. Rate certification letters were sent to CMS for review in November 2014 for implementation on January 1, 2015. A significant impact to rates in the second year is the breakthrough treatments for hepatitis C. HSD has been proactive in implementing a consistent clinical protocol among all the MCOs and the financial impact is reflected in the capitation rates. Given the uncertainty surrounding expenditures for these drug treatments, HSD has built a risk corridor into its Physical Health rates to mitigate potential losses. While these pharmaceutical impacts were not specifically anticipated in the budget neutrality projections, HSD believes the current per member per month trends per MEG are sound. HSD continues to monitor budget neutrality as detailed in Attachment A.

HSD continues to monitor eligibility and enrollment trends as they impact budget neutrality. HSD successfully completed a capitation mass adjustment for the first half of Centennial Care at the end of December 2014. In our previous quarterly report, HSD discussed these adjustments and confirms that they were completed. The adjustments reinforce the accuracy of budget neutrality monitoring, insuring that expenditures are reported properly in the correct MEG and align with member enrollment.

Section XI: Member Months Reporting

The table below provides the member months for each eligibility group covered in the Centennial Care program for this reporting period.

Table 12. Member Months for the Fourth Quarter

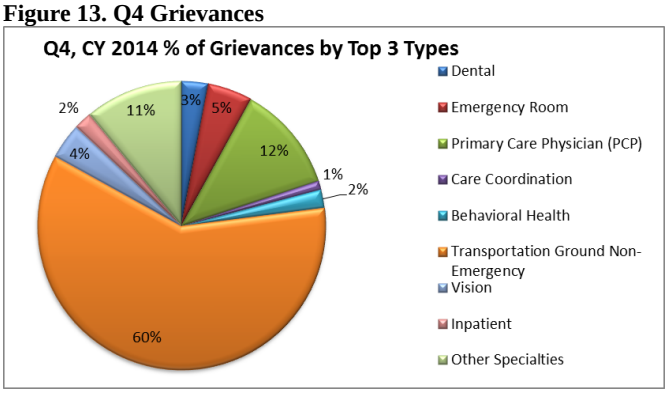
Eligibility Group	Member Month
Population 1 – TANF and Related	1,108,118
Population 2 – SSI and Related – Medicaid Only	125,122
Population 3 – SSI and Related - Dual	105,959
Population 4 – 217-like Group – Medicaid Only	683
Population 5 – 217-like Group - Dual	6,556
Population 6 – VIII Group (expansion)	559,349
Total	1,905,787

Please see Attachment E for New Mexico's statement that certifies the accuracy of this information.

Section XII: Consumer Issues (Complaints and Grievances)

A total of 657 grievances were filed by all Centennial Care members in the fourth quarter. Ground transportation non-emergency continues to constitute the largest number of grievances reported with 263 (60 percent) out of the 437 top three types of grievances received by all MCOs.

Figure 13. Q4 Grievances



The MCOs continue to report that actual grievances-per-thousand-trip count continue to remain low as the number of trips are continuing to increase monthly. MCOs also express a continued commitment to work on reducing member dissatisfaction with transportation services through efforts of increasing routine meetings with and feedback to their individual transportation vendors and through implementation of action plans as necessary.

Fifty-four (12 percent) of the total 437 top three grievance types reported were regarding PCPs and forty-seven (11 percent) were regarding other specialties. These grievances included issues of rude office staff, requests for pain medications that were not provided and a variety of other issues that do not indicate any specific trends. The remaining 73 (17 percent) top three types of grievances consist of less than five percent of any specific type. Within each of these types there were no identified trends.

Section XIII: Quality Assurance/Monitoring Activity

In addition to the care coordination audit activities discussed in section VI, HSD continued to audit various MCO standards, including high versus low NF LOC determinations, NF LOC denials, and service plans to ensure that member goals are reflected appropriately in the plans. This on-going auditing and monitoring has not identified any significant concerns.

Service Plans

The HSD/MAD Quality Bureau (QB) reviewed all service plan reduction requests for the first six months of Centennial Care. The MCOs submitted all service plan reduction proposals to the QB for review and approval prior to any reduction implemented. QB will perform an annual audit of service plan reductions for transitioning members. Audit results will be included in the Centennial Care 2015 quarter one report. The QB 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 that the MCOs are appropriately allocating time and implementing the services identified in the member's comprehensive needs assessment, and that the member's goals are identified in the care plan. Quarter four does not identify any concerns, however a conflict of time needed and time allotted for personal care services was identified with a December 2014 review of the service plans. Upon being informed of this finding the MCO then reviewed the member's allocation tool, corrected it and had its Medical director re-review and increase the member's hours.

Nursing Facility Level of Care (NF LOC)

QB 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 the fourth quarter.

Table 14. 2014 NF Level of Care Audit Quarterly Totals

High NF denied requests (and downgraded to Low NF)	**Quarter 1 2014**	**Quarter 2 2014**	**Quarter 3 2014**	**Quarter 4 2014**
Number of member files audited	31	42	16	15
Number of member files that met the appropriate level of care criteria	31	42	16	15
Percent of MCO level of care determination accuracy	100%	100%	100%	100%

Community Benefit denied requests	Quarter 1 2014	Quarter 2 2014	Quarter 3 2014	Quarter 4 2014
Number of member files audited	36	53	14	16
Number of member files that met the appropriate level of care criteria	36	53	14	16
Percent of MCO level of care determination accuracy	100%	100%	100%	100%

Table 15. 2014 Service Plan Audit Q4

Service Plans	Quarter 4 2014
Number of member files audited	120
Percent of service plans with personalized goals matching identified needs	100%
Percent of service plans that hours allocated matched need*	100%

*Technical assistance is given to the MCOs when the allocation of hours does not match identified need(s).

Section XIV: Managed Care Reporting Requirements

MCOs are required to submit monthly, quarterly, semi-annual, and annual reports, as well as ad- hoc reports, as needed. During the fourth quarter, HSD reviewed all current reports, and in conjunction with the MCOs, determined that several reports could be eliminated (e.g. weekly transition reports) or merged with other reports. As a result of this evaluation, the total number of reports was reduced from 95 to 80 in October 2014.

Evaluation of MCO reporting requirements is ongoing. HSD revised MCO reporting packages in groupings. Several reports are slated for final revision in December 2014 to streamline and improve data reporting and evaluation.

Behavioral Health Reports

The Utilization Management Report (Report #41) was revised during the third quarter, and was finalized on December 15, 2014. Report #41 was expanded to include PH, LTC and BH utilization data. The Core Service Agencies Report (Report #45) has undergone significant revision in order to capture critical unduplicated data regarding BH services provided to members. HSD recently received these revised report submissions and is in the process of analyzing the data.

Customer Service Reporting

Call Center Metrics

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

BCBSNM met contract standards for each customer service line with the exception of the nurse advice line (NAL) in November. The contract requires each line be answered within 30 seconds 85 percent of the time. BCBSNM met contract standards in September with 86.4 percent calls answered within 30 seconds and in October with 85.5 percent of calls answered within 30 seconds. BCBSNM did not meet the contract standard in November with 80.5 percent of calls answered within 30 seconds. BCBSNM indicated contract metrics were not met due to higher call volumes and longer wait times during the flu season. To ensure contractual requirements, BCBSNM addressed the issue by adding staff, incentivizing overtime, and limiting staff absences. Contract standards were met for all other customer service lines from September through November.

Appeals

A total of 428 appeals were filed by members of all MCOs in the fourth quarter. Of the total appeals filed, 262 (61 percent) were upheld, 148 (35 percent) were overturned and the remainder are still pending resolution. All MCOs have processed appeals in a timely manner.

Denial or limited authorization of a requested service were 388 (91 percent) of the appeals for all MCOs combined. Review of appeals data by MCO has identified no specific trends.

Section XV: Demonstration Evaluation

HSD received the Evaluation Design Plan approval letter in October 2014. As previously reported, HSD began contract negotiations with the selected vendor in late August 29, 2014. Currently, HSD is in the procurement process and no public information has been released regarding this tentative award. Formal notification of award will follow after successful completion of the final contract.

Section XVI: Enclosures/Attachments

Attachment A: Budget Neutrality Table (October 2014-December 2014)

Attachment B: GeoAccess PH Summary Q3WY1

Attachment C: GeoAccess BH Summary Q3WY1

Attachment D: MCO Action Plans

Attachment E: Member Months Statement of Accuracy

Attachment F: Centennial Care Contract Amendment #2

Section XVII: State Contacts

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

Section XVIII: Additional Comments

As there have been so many success stories with Centennial Care, HSD has included success stories from members enrolled with the Centennial Care MCOs who have had positive experiences with care coordination and other unique aspects of Centennial Care.

Centennial Care Success Story #1

This member was initially hesitant about allowing a care coordinator into his house. But upon meeting with the care coordinator at home, the member and his wife relaxed. The member stated that he felt depressed and hopeless. He lost a good job five years ago and the loss has affected his health care and self-esteem. As a result, he had gained weight, stopped riding his bike and began isolating himself from others. The member had chronic back pain and his vaccinations were not up to date. He had not seen a PCP, eye doctor, or dentist in five plus years. During this meeting with the care coordinator, he called and set up an appointment with a PCP for the next week. Together, they wrote down all the issues the member wanted to address with his PCP. His wife agreed to go with him to the appointment. After the initial PCP appointment and follow-up appointments, his vaccinations and lab work were completed. He found out he had diabetes and attended diabetes classes. He followed his plan and lost 25 pounds. His chronic back pain improved, and he is no longer taking ibuprofen every day. He rides his bike at least three times a week, up to 10 miles. He continues to take antidepressants but states he is feeling much better about life and self. The member has glasses now, and had a diabetic eye exam. He has seen the dentist and had some infected teeth pulled. His blood pressure has decreased and he is taking less medication. Since losing the weight, the member no longer has sleep apnea. He has not found employment, but has started writing a book.

Centennial Care Success Story #2

A care coordinator met with a member and observed that the member did not like to leave her home very often. There was a step at the member's front door that was difficult for her to navigate, and she preferred to drive her vehicle to the end of the driveway and enter her house through the back door. However, this back door was outfitted with a rundown, warped and rotting ramp, poorly built by some of her family members several years before. The ramp had a very steep incline, no handrails, and the boards were becoming twisted and unsteady. The screws on the ramp were starting to come up, and they could have easily cut, scraped or tripped her. Her safety was at risk.

The member is obese and was interested in having bariatric surgery. Her doctors told her that she needed to lose weight and increase her exercise by walking more. Our member's fear of falling on the ramp made her hesitant to leave her house to get this needed exercise and over time, she had become increasingly isolated and sedentary.

The care coordinator began working with the member to help increase her mobility, improve her safety and reduce her fear of falling. The proper DME and personal care services were put into place to assist the member with mobility and transfers. Her friends and family did not have the resources or skills to improve the existing ramp. After exhausting local volunteer resources, the care coordinator helped to facilitate the build of a new ramp through the environmental modification service process.

When the care coordinator followed up with this member recently, the member noted that she was thrilled with the results and impressed with her new ramp's gradual incline, sturdiness and stable handrails. Because of the new ramp, our member now feels incredibly at ease coming and going from her home and is venturing out of the house regularly. She now feels less isolated and has dramatically increased her walking and activity.

Centennial Care Success Story #3

A member was initially uninterested in talking with a care coordinator when she reached out to him to assist with completing an HRA. When she attempted to follow-up with him, his phone had been disconnected. Later, HSD requested that the MCO reach out to this member, as HSD had received a call from his concerned friend/advocate. The friend had stated that the member "really needed help," and said that he was now open to care coordination.

The care coordinator and a peer support manager met with the member at the motel where he was living and talked with him at length. This member has many barriers, including a serious felony on his record which is severely limiting his options for housing resources in New Mexico. The care coordinator and manager began exploring other options with this member, including out-of-state residential facilities for long-term substance abuse treatment. Since this visit, the member now calls his care coordinator two to three times a week to check-in and discuss the progress he is making in continuing to access substance abuse support groups, his therapist, his psychiatrist and other resources. It seems that what has made the biggest difference to the member is that he now knows there are two people at the MCO that are there for him, providing encouragement, support and hope.

Centennial Care Success Story #4

A 41 year old member was barely able to walk due to scoliosis, disk disorder, bone spurs, and arthritis. She had rods placed in 1988 and removed in 1998 due to her small stature creating issues with the rods. She had been in so much pain that her weight plummeted to 74 pounds. The member was having difficulty with her PCP and was discharged from a pain management program. A care coordinator referred the member to another PCP and attended the first appointment with the member to assist her in relaying concerns and discussing a plan of action. The care coordinator also

connected the member with a new pain management program and attended that first appointment with her. Following this appointment, the care coordinator brought concerns from the pain clinic to the MCO's Medical Director to ensure there would be no disruption of care. The Medical Director was helpful in ensuring the member received needed services. The member was walking with a cane, sometimes crawling, unable to bathe herself, or clean her home. The care coordinator arranged for personal care services for her. The MCO also approved an MRI, injection and appropriate pain medication under the care of the pain management program. The member reports that she is now walking without a cane, her pain is well controlled, and she is now able to bathe and clean her home independently, is sleeping through the night, is eating multiple times per day, and is gaining weight. The member no longer has the need for personal care services and is job hunting. The member has communicated that she is extremely grateful to the MCO and stated that her life has changed for the better.