NEW MEXICO MEDICAID PROGRAM – CENTENNIAL CARE

Beginning its fourth year in 2017, Centennial Care is changing the healthcare delivery system in New Mexico with a focus on integrated care, including robust care coordination, and its four guiding principles:

- To create a single, comprehensive delivery system;
- To provide incentives for individuals to take personal responsibility for their health;
- To advance Payment Reform strategies that reward improved outcomes; and
- To seek administrative simplification for the State, for providers and for members.

Medicaid Enrollment Greater than Originally Projected: (as of December 2016)
The Medicaid program has experienced significant growth in the past three years. In 2013, we had 37,000 adults in the State Insurance Program and now have more than 250,000 adults in the expansion program—a 575% increase

- Total in Medicaid 885,970
- Total in Centennial Care 680,399
- Total in Adult Expansion 257,649
- Total in Long-Term Care 34,947
- Total Accessing Community Benefit in 2014 24,013
- Total Accessing Community Benefit in 2015 27,836
- Total Accessing Community Benefit in 2016 27,593 (nine months only)

Centennial Care Accomplishments

- Approximately 950 care coordinators have been hired by MCOs
- 610,000 health risk assessments administered to members
- Standardized Health Risk Assessment (HRA) across four MCOs
- Increased Use of Community Health Workers (CHWs)—more than 100 CHWs are employed or contracted by the MCOs
- Increased number of members being served by Patient-Centered Medical Homes—increased from 200,000 members at the end of 2014 to 250,000 member at the end of 2015
- Launching of Health Homes on April 1, 2016 to provide integrated care for Medicaid recipients with chronic conditions, targeting a vulnerable population with behavioral health needs. The Health Home model has been successfully implemented in San Juan and Curry counties and serves approximately 350 members.
- Implementation of Electronic Visit Verification (EVV) to ensure that members are receiving authorized personal care services at the day and time approved. EVV was implemented statewide in November 2016.
- Launched Pilot Project to identify Super-Utilizers in September 2015 and continuing in 2017 with review of members in each MCO with the highest Emergency Department (ED) utilization. For the initial 40 members identified, ED visits decreased from 118 visits to 79 over a 12 month period. The top events for ED visits were alcohol use (45%), behavioral health (21%), and pain (17%). In May 2016, expansion of the project included adding 25 more members per MCO for a total of 140 project members. MCOs have been asked to implement care coordination interventions to reduce ED utilization for these members and develop effective strategies for improved management of super-utilizers.
- Additional MCO efforts to reduce non-emergent ED visits through the formation of a workgroup developing initiatives that include improved communication between care coordinators and community providers such as Emergency Medical Services (EMS) personnel, physicians/PCPs, and hospitals. MCOs are purchasing Emergency Department Information Exchange (EDIE) software and negotiating contracts with NM hospitals for instant notification when a member is in the ED to allow for earlier and more efficient care coordinator involvement.
- Molina Healthcare of New Mexico pilot project for the implementation of care coordination for justice-involved members in Bernalillo County Detention Center. As of October 28, 2016 approximately 128 referrals to date have been made. The goal is to expand the project to all the MCOs and to implement in other detention centers statewide in 2017.
- MCO performance on HEDIS measures exceeded 2015 national benchmarks for:
  - Annual dental visits
  - Behavioral health members with a follow up visit after an inpatient stay
  - Child immunization status
  - Well-child visits in first 15 months of life
  - Alcohol and other drug dependency treatment

**Centennial Care Improvements**
- Continued efforts to improve access to specialty providers includes, increased access to both physical and behavioral health care through an expanded utilization of telemedicine in rural and frontier settings.
- Continued expansion of Hepatitis C treatment to the five stages for which there is medical evidence indicating the benefit of treatment (F2, F3, F4, decompensated cirrhosis, hepatocellular carcinoma).
- The percent of Unreachable Members decreased to 11.6% with 248,513 “unreachable” members successfully reached by the MCOs during the Unreachable Member Campaign (September 2014 – June 2016).
 Supporting Provider Capacity

- Maximizing Scopes of Practice for Certain Providers. In order to increase the use of non-independently licensed master’s level behavioral health practitioners HSD has instituted a supervisory certificate for which providers attest to practice board and HSD approved supervisory protocols. In this way agencies providing services to Medicaid beneficiaries can expand their access to care through utilization of an expanded number of practitioners. We have also authorized the use of independently licensed psychiatric certified nurse practitioners, certified nurse clinicians, and prescribing psychologists where previously only psychiatrists could render services for some of our specialty psychiatric services.

- The acquisition of audio-visual equipment for several provider practice sites to enable the provision of telemedicine services to members.

- Increasing the use of Community Health Workers (CHWs)
  - CHWs work with high ED utilizers to redirect them to PCPs, educate about healthy behaviors, disease management, and community resources;
  - MCOs partnering with UNM to expand role of CHWs – care coordination, health education, health literacy, translation, and community supports linkages;
  - 2017 Delivery System Improvement Target requires MCOs to increase utilization of CHWs by a minimum of 10% over the 2016 baseline.

- Unbundled reimbursement for Long-Acting Reversible Contraceptive (LARC) provided through Federally Qualified Health Centers (FQHCs)

 Measures of Success

- MCOs reported member satisfaction through the 2015 Consumer Assessment of Healthcare Providers and Systems (CAHPS). The target populations included; adults, children and children with chronic conditions, who were enrolled in Centennial Care in 2014. Results of the survey were compared to the 2014 National benchmark as stated in the National Committee for Quality Assurance (NCQA) Quality Compass.
  - Rating of Healthcare for the adult population reports an average satisfaction rate among the four MCOs of 85.1% which is above the national benchmark of 84.7%.
  - Coordination of Care average for the adult population reports an average satisfaction rate among the four MCOs of 84.7% which is above the national benchmark of 81.0%.
  - Rating of Healthcare for children (general population) reports an average satisfaction rate among the four MCOs of 85.1% which is above the national benchmark of 84.7%.
  - Coordination of Care average for children (general population) reports an average satisfaction rate among the four MCOs of 84.7% which is above the national benchmark of 81.0%.
  - Rating of Healthcare for children (chronic conditions) reports an average satisfaction rate among the four MCOs of 79.07% which is below the national benchmark of 83.3%
Coordination of Care average for children (chronic conditions) reports an average satisfaction rate among the four MCOs of 84.05% which is above the national benchmark of 79.8%.

CMS mandates three annual External Quality Review (EQRO) audits. The EQRO’s review methodology followed the established CMS protocol. All four MCOs were awarded full compliance in 2014 in the areas of:

- Compliance of contractual requirements including enrollment/disenrollment, member materials, member services, provider network, care coordination, grievances and appeals, and program integrity.....
- Performance measure validation
- Performance improvement plan validation.

Secret Shopper Survey
HSD conducted a Secret Shopper Survey of providers in August 2016. Over 300 primary care providers (PCP) and specialty providers were randomly selected and contacted. Highlights of survey results are:

- On average, except for new patient cardiology appointments, the time-to-appointment timeframes for new, established and urgent patient appointments were met, or appointments were offered earlier than managed care contract standards
- 13% of PCPs offer extended hours (evening or weekend hours, or both)
- 93% of PCPs who were reached accept Medicaid, and of those, 88% are 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
- On average, established patients who identified as sick or needing an urgent appointment could be seen within 1 business day.

All MCOs continue to increase the use of telemedicine visits in 2016. The 2017 Delivery System Target requires MCOs to increase utilization of telemedicine office visits with specialists a minimum of 15% in 2016. Targets were developed based on the MCO’s baseline number of telemedicine visits in 2015. One MCO’s baseline was 2,043 visits in 2015, however this MCO has significantly increased and reported 3,501 visits through the third quarter of 2016. All MCOs increased their members being served in a Patient Centered Medical Home (PCMH) by 5% or maintained a minimum of 40%, meeting the PCMH Delivery System Target.

- One MCO had 53% of their members being served in a PCMH.

70 percent of members are participating in Centennial Care Member Rewards Program that offers rewards for engaging in healthy behaviors; adding reward for management of hypertension in 2016 as data suggests high prevalence and costs for this condition among the population.
Care Coordination
Care Coordination is the cornerstone of Centennial Care. It involves provider collaboration to coordinate member health services to achieve physical, behavioral, and long-term care goals for Medicaid recipients.

- A standardized Health Risk Assessment (HRA) was finalized and implemented by all MCOs July 1, 2016 for use in assessment of newly enrolled Medicaid members or members with a change in health condition. The requirement for an annual HRA for existing members was deleted in Amendment #6 of the managed care contracts effective July 1, 2016.
- Members in need of a higher level of care coordination receive a Comprehensive Needs Assessment (CNA) to assess physical, behavioral, and long-term care needs.
- Members in Level 2 or Level 3 must work with an assigned care coordinator to develop and implement an individualized care plan based on a person-centered approach that includes the member’s unique needs and preferences.
  - Care Coordination Level 2 members receive:
    - Semi-annual in person visits
    - Quarterly telephone contact
    - Annual CNA to determine if the level of coordination and care plan are appropriate
  - Care Coordination Level 3 members receive:
    - Monthly telephone contact
    - Quarterly in-person visits
    - Semi-annual CNA to determine if the level of coordination and care plan are appropriate

Community Benefit
Prior to the implementation of Centennial Care, recipients received home and community based services (HCBS) through allocation to the HCBS waiver. In Centennial Care, all members with a Nursing Facility Level of Care may receive home and community based services, known as the Community Benefit (CB) package. More than 27,000 members are receiving home and community based services. Personal Care Services (PCS) is the most utilized CB service. Total PCS expenditures have increased from $263 million with 19,500 users in 2013 to $345.8 million with 27,836 users in 2015.

Under Centennial Care, NM has continued to reintegrate members from nursing facilities into the community, with 85.7% of members in the long-term care program being served in the community in 2015. In the AARP’s annual report for 2014, State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities and Family Caregivers, New Mexico ranks first in the nation for spending more than 65 percent of its long-term care dollars on home and community-based services.
**Community Intervenors**
Centennial Care allows eligible deaf-blind members to work one-on-one with Community Intervenors, who provide critical connections to services and the community:

- Open channels of communication between the individual and others
- Help to provide access to information
- Facilitate the development and maintenance of self-directed independent living

**Member Rewards Program**
The Member Rewards Program was developed to encourage members to become more active participants in their healthcare.

- As of November 2016, 206,229 members have registered to earn credits in the program ([www.CentennialRewards.com](http://www.CentennialRewards.com)).
- Members earn rewards by making healthy choices and taking part in specific programs:
  - Healthy Smiles to promote dental care
  - Bone density testing
  - Step-Up Challenge for exercise and weight loss
  - Perinatal Program, which includes the first trimester prenatal visit, post-partum visit, and first well-baby check (or third trimester visit)
  - Managing asthma through controller refills
  - Managing diabetes through HbA1c and LDL testing
  - Managing schizophrenia and bi-polar disorder through regular appointments and medication management

**Native American Advisory Meetings**
The Native American Technical Advisory Committee (NATAC) was established in September, 2012 as a subcommittee to the Medicaid Advisory Committee to give the Tribes, Pueblos, and Nations an opportunity to meet with the New Mexico Medicaid Director on a quarterly basis. The focus of these meetings is to:

- Advise the Medicaid program about how to best to communicate with Native American Centennial Care members, work with Indian Health Services (IHS), Tribal and urban health providers, and to facilitate successful reimbursement while reducing administrative burden.
- Meet with Tribal leaders, Indian Health Service and Tribal health providers to address issues related to enrollment, access to care, and payment for services.
- Continue a discussion around Centennial Care, to identify concerns and best practices, and for the committee members to make recommendations on how to best address these concerns and track the progress of our efforts.

In addition, New Mexico HSD/MAD partnered with IHS/Tribal 638 facilities to develop the process for the 100% Federal Medical Assistance Percentage (FMAP) for services received through an IHS/Tribal 638 facility furnished to Medicaid eligible Native Americans.
Implementing Payment Reform Projects
HSD implemented payment reforms that reward providers for performance on quality and outcomes that improve members’ health. In early 2015, HSD approved 10 payment reform projects; all projects launched in July 2015, including:

- Accountable Care Like Models – Performance-based model with partial payment paid as bonus for achieving quality outcomes
- Bundled Payments for Episodes of Care – Bariatric surgery, diabetes, and maternity
- Patient-Centered Medical Home Shared Savings – Built upon PCMH model by adding shared savings targets that reward achievement of utilization and quality targets

HSD collaborated with the MCOs to develop quarterly reporting templates and agreed-upon set of metrics that included process measures and efficiency metrics.

MCO Delivery System Improvement Performance Targets for Calendar Year 2017

<p>| Community Health Workers (CHWs) | A minimum 10% increase in the number of members served by Community Health Workers (CHWs) for care coordination activities, health education, health literacy, translation and community supports linkages in Rural, Frontier and underserved communities in Urban regions of the state above the MCO’s CY16 baseline number. Each MCO shall submit for HSD approval a delivery system improvement performance project that is designed to increase the number of members served by Community Health Workers (CHWs). The project for 2017 shall elaborate on the Contractor’s efforts to create a sustainable funding stream for CHW work and include a plan to extend such efforts to provider practices and clinics on behalf of Medicaid Members by the end of 2017. The MOC’s submission should include: (1) a brief description of the project’s third year; (2) clearly stated goals for 2017 that can be validated with data; (3) a discussion of the CY16 baseline from which the MCO is expected to progress and the data used to determine the CY16 baseline; and (4) a discussion about measuring progress toward the goals and the data used to measure progress. The MCO’s plan shall be submitted to HSD by February 1, 2017 and HSD will provide feedback/approval within two (2) weeks of receipt of the MCO’s plan. The MCO shall provide quarterly reports to HSD of the number of CHWs hired by the MCO and the number of community-based CHWs that will be supported by the CONTRACTOR for provider practices and clinics by the end of 2017, as well as an analysis of trends observed. The quarterly reports are due to HSD 30 calendar days after the quarter’s end. |
| Telemedicine | A minimum of a fifteen percent (15%) increase in telemedicine “office” visits with specialists, including Behavioral Health providers, |</p>
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient-Centered Medical Homes</strong></td>
<td>A minimum of a five percent (5%) increase of the MCO’s Members being served by Patient-Centered Medical Homes (including both PCMHs that have achieved NCQA accreditation and those that have not). The MCO shall use 2016 experience as a basis to measure an increase in 2017, and shall submit 2016 experience to HSD by February 1, 2017. If the MCO achieves a minimum of 45% of membership being served by PCMHs, verified with data submission on February 1, 2017, then the MCO must maintain that same minimum percentage at end of calendar year in order to meet this target.</td>
</tr>
<tr>
<td><strong>Hepatitis C</strong></td>
<td>The MCO shall treat at least 75% of the MCO’s target number of patients receiving Hepatitis C drug treatments (which were included in the capitated rate) during the contract period. Treatments are defined as the number of unique members who have an initial pharmacy encounter for one or more of the Hepatitis C drugs as identified in the MCO payment rate signature sheets including periodic updates made by HSD to the Hepatitis C drug list. The MCO must meet 75% of its target for the combined Physical Health, Medicaid Only LTSS, and Other Adult Group populations for CY 2017. An individual who has started treatment and has a Hepatitis C pharmacy encounter before the end of the contract period will be counted in this measurement. Individuals who started treatment during CY2016 and continue treatment into CY2017 will not be considered when HSD performs this measurement. The target will be adjusted at the end of the calendar year based on the MCO’s final proportion of membership in each of the three populations.</td>
</tr>
<tr>
<td><strong>Value Based Purchasing (VBP)</strong></td>
<td><strong>ALL MCOs:</strong> The MCO must implement value based purchasing. In order to meet...</td>
</tr>
</tbody>
</table>
Note: There is a variance in contract language for UHC only.

the target, the MCO must have met the percentages established in the table below in all three levels; however, MCOs with more advanced VBP strategies may substitute higher percentages in Level 2 and/or Level 3 for lower percentages in Level 1; or MCO may substitute higher percentages in Level 3 for lower percentages or requirements in Level 1 and Level 2 as long as the overall target of 16% of payments in VBP arrangements is met for the calendar year.

### All MCOs:

<table>
<thead>
<tr>
<th>VBP LEVEL 1</th>
<th>VBP LEVEL 2</th>
<th>VBP LEVEL 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>A minimum of 5% of all MCO provider payments* for dates of service between January 1, 2017 and December 31, 2017 will meet the following criteria:</td>
<td>A minimum of 8% of all MCO provider payments* for dates of service between January 1, 2017 and December 31, 2017 will meet the following criteria:</td>
<td>A minimum of 3% of all MCO provider payments* for dates of service between January 1, 2017 and December 31, 2017 will meet the following criteria:</td>
</tr>
<tr>
<td>• Fee schedule based with bonus or incentives and/or withhold (at least 5% of provider payment)— available when outcome/quality scores meet agreed-upon targets.</td>
<td>• Fee schedule based, upside-only shared savings— available when outcome/quality scores meet agreed-upon targets (may include downside risk), and</td>
<td>• Fee schedule based or capitation with risk sharing (at least 5% for upside and downside risk); and/or</td>
</tr>
<tr>
<td></td>
<td>• Two or more bundled payments for episodes of care.</td>
<td>• Global or capitated payments with full risk.</td>
</tr>
</tbody>
</table>

### Additional requirements for VBP in CY 2017

- At least 3% of the overall 16% in VBP contracting must be with high volume hospitals and require readmission reduction targets of at least 5% of the hospital’s baseline.
- MCO must include payments to behavioral health community providers in calculating the percentage of overall spend in its VBP arrangements.

*MCOs may exclude provider payments for dually-eligible members from the calculation.