Centennial Care Waiver Demonstration

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

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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% of the State’s total General Fund budget each year. In State Fiscal Year 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. 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 where possible

The culmination is the development and implementation of Centennial Care, a comprehensive, integrated delivery system for Medicaid that integrates physical, behavioral and long-term care 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 2013 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 (BCBS)
- Molina Healthcare of New Mexico
- 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 and risk stratification. 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, behavioral and long-term care 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 behavioral health 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

Eligibility
New Mexico has expanded Medicaid eligibility to childless adults under the Affordable Care Act (ACA). As noted in the table in Section III of this report, there have been 113,528 new enrollees into the expansion/VIII group who are in Centennial Care.

Enrollment
Centennial Care enrollment has continued to increase each month in the first quarter. Expansion of Medicaid eligibility as described above 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 has addressed sporadic and isolated disenrollment of Centennial Care members in the first quarter. This is partially associated with the implementation of new modified adjusted gross income (MAGI) rules as required by the ACA, the surge of applications due to the expansion of Medicaid eligibility, and the implementation of New Mexico’s new eligibility system ASPEN (Automated System Program and Eligibility Network). HSD does not expect such problems to persist in subsequent quarters.

Access
HSD is in the process of reviewing the first round of monthly reports from the MCOs that track access to care. No trends have been identified at this time. HSD has no anecdotal reports of access to care problems. More information will be available in the next quarterly report to CMS.

Service Delivery
Care coordination is one of the key changes implemented in Centennial Care that ensures effective service delivery. Previously, all services were provided separately with no formal collaboration between providers. Care coordination utilizes a model similar to case management where members who are at the highest risk for poor health outcomes are guided through the system by a care coordinator and are assigned to a care coordination level 2 or 3, based on their assessment results. Care coordinators then focus on developing personalized plans for members that ensure all the necessary services needed are coordinated collaboratively with the member and provided in a timely manner. This model ensures that members have one point of contact for all of their physical and behavioral health needs, providers are aware of services and medications received from other physicians, and member-centric plans of care. According to the Centennial Care contract, MCOs are required to conduct the health risk assessment (HRA) within 30 calendar days of new member enrollment and 180 calendar days of enrollment for transitioning members from legacy Medicaid programs.
New Mexico monitors the prior authorization (PA) process as one of the early indicators of service delivery effectiveness. PAs received, approved and denied are monitored on the transition report. PA requests for new services must be processed within 14 calendar days for new services and within 10 calendar days to continue ongoing services. HSD monitoring of this process identified several issues including the following:

- PHP self-identified an internal issue resulting in a back-log of PAs in early implementation, and initiated a corrective action plan that ran from January 29, 2014 to March 31, 2014.
- An issue involving PHP about carrying “double PAs” for single member/single service, which would impact electronic visit verification (EVV) implementation, has been identified; this issue was pointed out to PHP by HSD, and PHP has initiated a plan to address.

A monthly pharmacy report tracks PAs for pharmaceuticals and the quarterly PA report captures all other PAs. MCOs were instructed to honor PAs from legacy programs as they were implementing their Centennial Care PA processes. This HSD decision avoided transition problems.

HSD has monitored MCO contracting status on a weekly basis. The quarterly geo-access report was received on April 30, 2014, and is still being analyzed.

There have been challenges regarding PAs for nursing home stays. Processes were developed to assist nursing facilities in transitioning their residents into Centennial Care. One county was not connected to the new ASPEN system until late January so accommodations had to be made to meet the needs of nursing facilities located in that county. Multiple trainings, memos and letters of direction were distributed to providers and MCOs to facilitate the submission and approval of PAs, both for new members and for continued stays.

Technical assistance meetings with the MCOs continue. Specific HSD staff persons have been identified to work with providers one-on-one to resolve these issues as well as other concerns regarding billing, eligibility, timely review of nursing facility level of care (LOC) packets as well as concerns regarding submission of approvals for LOCs through the ASPEN system. Ongoing meetings continue among the New Mexico Health Care Association (representing the nursing homes), MCOs, providers and HSD staff to resolve issues in a timely fashion.

**Provider Network**

The MCOs’ primary care provider (PCP)-to-member ratios are well within the established Centennial Care contract standard of 1:2000 with a compliance range of 1:6 – 1:91 with the exception of one MCO. The percentage range of PCP panel slots open to accept new patients is 93-98%.

The first quarter reports show that three of the four MCOs meet the contract standards for PCP-to-member ratios. MCOs report sufficient access to physical health, dental, hospital, long-term
care and transportation providers, but the lack of certain specialties (≤90%) was identified in some areas of the State, especially in the rural and frontier areas.

All MCOs have taken actions to improve access including: review of GeoAccess reports in depth to accurately identify areas of concern that may occur as a result of provider terminations or providers with closed panels; identifying potential providers, taking into consideration current capacity, network deficiencies, service delivery issues and future needs relating to growth in membership and long-term care service needs; monitoring enrollment trends, member demographics, service utilization, and provider terminations; locating potential providers in specialties of concern and approaching each to be contracted with the MCO; identifying providers interested in the use of telemedicine as an alternative for members residing in rural and frontier regions; and providing assistance to members with referrals to the closest available providers as well as using contract single case agreements to provide members with the care they need. If necessary, the member’s transportation to these providers is arranged.

During weekly calls with each MCO, HSD reviewed the MCO networks and contracting status, including contracting status with Core Service Agencies (CSAs) for behavioral health services. MCOS are not required to contract with Indian Health Services Tribally Operated and Urban Programs (I/T/Us). All MCOs are required to allow members to access care at I/T/Us and to reimburse the I/T/Us at the Office of Management and Budget (OMB) rate.

Changes or Anticipated Changes in Populations Served and Benefits
At this time, there are no anticipated changes in populations served or changes in benefits.

Demonstration Amendments
There are no amendments being implemented in this quarter.

Member Rewards Program
The Centennial Rewards website, catalog, and call center were all operational by the go-live date of January 1, 2014. Members started earning credits for healthy behaviors on January 1, 2014 and can redeem earned credits beginning March 31, 2014. The first quarter was therefore limited to pre-implementation activities.

By the implementation date, all four Centennial Care MCOs had executed contracts with the same two vendors – Finity and Medagate. Finity is the primary contractor and is responsible for many aspects of the program including, but not limited to: the program website, call center, and rewards tracking. Medagate issues and manages the debit cards that are used by members to obtain rewards.

The first “healthy choices” activities for which members could earn rewards were:

- Healthy Smiles - annual dental check-up (child and adult)
- Healthy Babies – joining the MCO prenatal program
• Bone density testing

Asthma management, diabetes management, and medication management activities will be available during the second quarter (estimated start date for these activities is May 30, 2014).

Due to the program’s structure and the activities for which credits were available during the quarter, the majority of points were earned by children age 18 and under. However, credits were earned across the entire Centennial Care membership.

• A total of 31,874 members earned credits during the first quarter
• A total of 10.8 million credits were earned across all activities that were available during the quarter (a dollar value of $1.1 million)

HSD will have much more robust reporting on this program for the second quarter. We intend to report on:

• Number of registered accounts
• Number of participants earning credits
• Dollar amount of credits earned (total and by activity)
• Dollar amount of reward redemptions by category of reward
• Dollar amount of reward redemptions by activity
• Ratio of points/credits earned to items purchased/redeemed
• Qualitative narrative on the program’s successes and lessons learned

Community Interveners
According to the New Mexico Deaf-Blind Task Force, about 150 deaf/blind people reside in New Mexico – approximately 60 adults and 90 children. A very small percentage of them are Medicaid recipients and some of the adults may become eligible under the Medicaid expansion. A number of these adults and children use what the New Mexico Deaf-Blind Task Force call Community Interveners (CI) to help them negotiate the world, both in their homes and out in the communities.

The CI works one-on-one with deaf-blind individuals who are five years and older to provide critical connections to other people and the environment. The CI opens channels of communication between the individual and others, provides access to information, and facilitates the development and maintenance of self-directed independent living. CI services shall be provided through Centennial Care MCOs. (CMS Special Terms and Conditions, #31 – NM Centennial Care.)

The State finds the services of CIs to be of great value to its Medicaid members in that the services they provide allow deaf/blind people to be independent, productive and much more participative in New Mexico’s communities than they can be without these services. CIs help deaf/blind people avoid institutionalization and remain in their communities, leading to reduced
costs to Medicaid. The use of CIs aligns with the care coordination activities outlined in Centennial Care and the use of these individuals provides a specialized skill set and qualifications for members.

Minimum provider qualifications for a CI:

- Is at least 18 years of age
- Is not the spouse of the member to whom the intervener is assigned
- Holds a high school diploma or a high school equivalency certificate
- Has a minimum of two years of experience working with individuals with developmental disabilities
- Has the ability to proficiently communicate in the functional language of the deaf-blind member to whom the intervener is assigned
- Has completed an orientation or training course by any person or agency that provides direct care services to deaf-blind individuals
- (Pursuant to NMAC 8.308.9.12.)

At this time, there is only one provider able to contract with the MCOs for the CI service, Community Outreach Program for the Deaf (COPD). HSD developed a letter of direction (LOD) to the MCOs that outlines who is eligible for the CI services; provider qualifications; provides the federal definition for members who are deaf-blind; and includes the hourly reimbursement rate. The MCOs are following this LOD and are in the process of contracting, providing training on billing, PAs, and training with specific care coordinators on best practices for working with members who have deaf-blindness. HSD initially anticipates there will be a very low volume of members receiving the CI service. The MCOs will work with the provider to bring this service up and increase the number of Medicaid members receiving this service.

COPD currently provides CI services to individuals who are 16 and older. COPD currently employs 15 CI throughout the state. Those receiving this service typically receive approximately 20 to 25 hours per month. COPD is currently serving four Medicaid recipients. HSD anticipates Centennial Care members who are eligible will begin receiving CI services by the second quarter, once contracts are finalized between COPD and the four Centennial Care MCOs.

**Number of Participants Who Chose an MCO and the Number of Participants Who Changed Plans After Being Auto-Assigned**

A total of 521,105 members were assigned to a Centennial Care MCO in the quarter. Of that total, 388,366 members chose an MCO. This count includes members who transitioned from the SALUD or CoLTS program and who stayed in their SALUD or CoLTS MCO. It is important to note that, for care continuity purposes, members enrolled in a CoLTS or SALUD MCO that became a Centennial Care MCO automatically stayed in their MCOs unless they actively
selected a new plan. In addition, 116,542 members auto-assigned to an MCO and 16,197 participants changed plans at least once after being auto assigned.
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.

<table>
<thead>
<tr>
<th>Demonstration Population</th>
<th>Total Number of Demonstration Participants Quarter Ending – March 2014</th>
<th>Current Enrollees (Year to Date)</th>
<th>Disenrolled in Current Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population 1 – TANF and Related</td>
<td>375,556</td>
<td>375,556</td>
<td>21,186</td>
</tr>
<tr>
<td>Population 2 – SSI and Related – Medicaid Only</td>
<td>39,268</td>
<td>39,268</td>
<td>822</td>
</tr>
<tr>
<td>Population 3 – SSI and Related – Dual</td>
<td>32,877</td>
<td>32,877</td>
<td>965</td>
</tr>
<tr>
<td>Population 5 – 217-like Group – Dual</td>
<td>4,589</td>
<td>4,589</td>
<td>95</td>
</tr>
<tr>
<td>Population 6 – VIII Group (expansion)</td>
<td>125,523</td>
<td>125,523</td>
<td>5470</td>
</tr>
<tr>
<td>Totals</td>
<td>580,119</td>
<td>580,119</td>
<td>28,618</td>
</tr>
</tbody>
</table>
Section IV: Outreach

Between mid-August and the third week of November 2013, HSD conducted 222 education events throughout New Mexico. Of the 222 events, 59 were focused specifically on Native American New Mexicans. Events were held in 87 different cities and towns — most of them multiple times in the same location. HSD staff spent 81 days and 56 nights on the road and covered over 20,000 miles of New Mexico roads.

At the events, HSD described the changes to the Medicaid program under Centennial Care, explained which eligibility categories and services would be enrolled in Centennial Care and provided instructions and guidance on selecting an MCO. All four MCOs participated in the events by staffing tables with informational brochures, answering questions and making brief presentations on the value-added services they offer.

HSD staff participation included 29 Medical Assistance Division (MAD) employees and 12 Behavioral Health Services Division (BHSD) staff. Each event required three people — a presenter, an assistant who was available to answer questions during and after the presentation, and a “roadie” who set up the audio-visual equipment.

Well before the start of events, HSD began running radio and newspaper advertising promoting the change of the State's Medicaid program. Newspaper and radio ads were run state wide in English, Spanish and Navajo-language newspapers and radio stations.
Section V: Collection and Verification of Encounter Data and Enrollment Data

The Centennial Care demonstration population is categorized by MEGs. The MEGs are categorized by category of eligibility and cohort as defined by CMS 64 Federal reporting requirements. The enrollment counts for the populations in Section III align with the MEGs from the CMS 64.

In accordance with the contract, first calendar quarter encounter data is not due from the MCOs until early in the second calendar quarter of 2014. During the first quarter of 2014, encounter data submissions were tested and reviewed by HSD staff in collaboration with each MCO. First calendar quarter encounter data was received on time in the second quarter. HSD will report on encounter data beginning with the next quarterly report.
Section VI: Operational/Policy/Systems/Fiscal Development Issues

Program Development
HSD staff provided extensive training to appropriate MCO staff throughout 2013 in preparation for Centennial Care. Many of the activities required of the MCOs Centennial Care were new, reflecting added demographic groups and management of members in Medicaid. These training programs included:

- Care coordination (two separate trainings)
- Self direction
- Personal care services self directed
- Behavioral health
- PCP fee increase
- Provider billing
- Cost Sharing
- Federally Qualified Health Centers
- Nursing facilities
- Telehealth
- Deductibles and co-payments
- Use of pricing files
- Use of provider files
- Provider enrollment
- Crossover claims
- Alternative benefit plan
- Transition meetings (four separate trainings) with the Statewide Entity for Behavioral Health (pre-Centennial Care Behavioral Health program), each MCO and HSD staff to transition behavioral health members

HSD met at least bi-weekly with MCO staff during 2013 to discuss issues, questions and concerns in preparation for the implementation of Centennial Care. Agenda items in these meetings included:

- Claims payment contingency plans
- Care coordination staffing for
- HRAs
- Comprehensive Needs Assessments (CNAs)
- Health information exchange
- EVV
- I/T/U agreements
- Delivery system improvement targets
- Transition issues
- Behavioral health network
• Member rewards program
• Tracking out-of-pocket expenses
• Member materials
• Marketing materials
• Associated processes
• Safety net care pool
• Community interveners
• Fiscal management agency (SDCB) contract
• Encounter requirements (in addition to separate weekly systems meetings that continue)
• Nursing facility rates – high nursing facility (HNF) rates and low nursing facility (LNF) rates
• Transitional PAs
• MCO selection and open enrollment
• Network adequacy
• Deadlines for MCO deliverables
• Value added services
• Contract amendment
• Identified HSD Centennial Care Command Center (C4) process and MCO process

An integral part of readiness was the joint HSD/MCO workgroups and HSD desk audit teams. The desk audit teams performed all the readiness activities, including onsite audits with each MCO. The desk audit teams also reviewed and approved written materials submitted by the MCOs documenting their policies, procedures and protocols. The HSD/MCO workgroups met regularly – sometimes in conjunction with MCO representatives to discuss specific systems and policy issues related to the implementation of the Centennial Care program. The following is the list of HSD/MCO workgroups and desk audit teams.

• Administrative burden reduction workgroup
• Systems workgroup
• Member rewards workgroup
• Care coordination workgroup and desk audit
• Reporting workgroup
• Coding workgroup
• Level of care workgroup
• Self-direction workgroup
• Member education and outreach workgroup and desk audit
• Operations desk audit
• Program integrity desk audit
• Provider desk audit
• Finance desk audit
• Quality workgroup and desk audit
• Utilization management desk audit
• School-based health center workgroup
• Policy workgroup

The Centennial Care MCOs have participated with HSD in the Administrative Reduction Workgroup. The workgroup has representation from each Centennial Care MCO and HSD in order to streamline documents and processes for providers and to reduce the administrative burdens on providers.

Specifically, the Administrative Burden Reduction Workgroup will develop, among other items, forms, and templates related to (i) credentialing, (ii) provider audits, (iii) reporting, (iv) authorizations, (v) grievances and appeals, and (vi) forms for level of care determinations. (Centennial Care Contract, Section 4.11.4, Provider Workgroup.)

As a result of work of the Administrative Reduction Workgroup, HSD has issued:

• LOD #23, establishing guidelines that streamline processes for Critical Incident Reporting
• LOD #11, establishing billing and guidelines for non-independent licensure for behavioral health providers
• PAs for behavioral health services– emphasized to MCOs that PAs cannot be more restrictive than what Optum Health was (per LOD #11)

HSD and the MCOs have worked on revising Report 45, CSA Report 45 to reduce the administrative burden on providers having to submit information. Information on CSAs will now be provided by the MCO directly.

HSD and the MCOs will continue bi-weekly meetings to achieve the goals listed in the Centennial Care contract. (See Centennial Care Contract, Section 4.11.4, Provider Workgroup.)

HSD implemented a robust contract monitoring process for the MCOs’ regular reporting. The process includes: an intake process; a review and evaluation process; an escalation of identified areas of concern process; and a process for assessing penalties and sanctions as defined in the contract for MCO failure to provide timely and accurate reports and to meet specified contract metrics. There are approximately 96 reports per MCO (weekly, monthly, quarterly, semi-annual and annual).

Care coordination of all Medicaid members by the MCOs is the centerpiece of Centennial Care and HSD has been particularly focused on ensuring MCO success with this function. HSD monitored the MCOs to ensure they developed care coordination programs aligned with the central vision of Centennial Care.

Multiple structures and methods were established to monitor quality of care and identify early issues during the implementation stage of Centennial Care as follows.
Centennial Care Command Center

The C4 was established to provide prompt resolution of early implementation issues as well as early identification of issues or trends as they might arise. The C4 had a designated room with computers and phones and was staffed by subject matter experts in systems, eligibility, quality, and long-term care and with a leadership representative available for immediate decision making.

The C4 provided intake and triage of urgent issues involving providers and members during the implementation phase. Calls were received from multiple sources, including:

- Xerox (New Mexico Medicaid fiscal agent)
- MCOs
- Individual providers
- Service agencies
- Medicaid staff
- Provider associations
- Other state agencies, such as HSD’s Income Support Division (ISD) and the Department of Health

All issues received in the C4 were maintained on an issues log by an issues log owner. Appropriate Medicaid staff had access to the issue details on a shared network location. Individual issues were dated as received, identified by type of issue and urgency, and assigned to the Medicaid staff member most appropriate to manage and resolve. Issues that could be resolved during the call were addressed immediately by decision makers and subject matter experts who were staffing the C4.

For those issues that could not be resolved immediately, the staff member assigned to the issue would contact the concerns originator (provider, member, etc.) and would facilitate resolution of the issue with the MCO involved or the Medicaid process involved. For example:

- Member questions about services or enrollment would be followed up with the member’s MCO
- Eligibility questions would be coordinated with the appropriate MCO, ISD, Systems and Eligibility Bureau
- Provider payment issues were investigated and referred for follow up with the MCOs or internal Medicaid systems to insure proper billing and payment procedures for covered benefits were being followed

Prompt turnaround time for resolution of issues was expected and specific issues were discussed daily during transition period HSD/MCO calls.

Attachment B depicts the types of issues and their numbers that arose during early implementation of Centennial Care and were documented on the issues log.
HSD is proud of how smoothly the transition into Centennial Care has been to date, exemplified by the low number of initial concerns recorded in the command center issues log. As a result, the command center was closed earlier than anticipated on February 28, 2014. However the MCOs were instructed to continue raising issues with HSD contract managers and HSD continued to reach out to advocacy groups to address provider specific issues that initiative. HSD assigned two staff members to continue to receive concerns that were reported after the center closed.

**Transition Report and Daily HSD/MCO Calls**
In addition to C4, contract managers and HSD leadership had daily calls with the leadership of each MCO during the first quarter. The calls were designed to monitor implementation progress and to proactively identify any problems with implementation. Participants discussed general implementation issues and the data submitted on the daily Transition Report by each MCO (see Attachment C).

Contract managers analyzed the daily Transition Report, identified questions and concerns, and discussed them with each MCO individually during the daily calls.

The Transition Report elements included:

- Enrollment Information (membership, PCP assignment)
- PA (requests, approved, denied)
- Care coordination (nursing facility level of care, care coordination level of care, HRAs, comprehensive needs assessments, care plans)
- Complaints, grievances and appeals
- Claims (received, approved, denied)

The Transition Report was developed by HSD to monitor the early performance of the MCOs. Each MCO submitted their data each day by uploading their reports to the HSD network no later than 7:30 am each morning. HSD staff downloaded, printed and created packets for the HSD Centennial Care transition team. Contract managers analyzed the data and set their agendas for discussion topics. The transition team met at 9:00 am to discuss identified issues and the meeting agenda. MCO calls began at 9:30 am each day and lasted 30 minutes, at the most.

**Behavioral Health Services Readiness**
HSD focused on addressing implementation issues related to the integration of behavioral health services in Centennial Care. HSD brings together high-level MCO behavioral health managers with the CEOs of the primary behavioral health providers (CSAs) to work through implementation issues. The meetings began several months before Centennial Care go-live and continue on a bi-weekly basis.

The MCO/behavioral health provider meetings are conducted every other Monday. Discussions address systems issues like contracting, credentialing, critical incident reporting, care coordination, pharmacy and PA issues. The meetings are also useful for sharing contact
information, program experiences, innovative services and developments in the field. Over time, the meetings have improved communications between the MCO care coordinators and the providers’ direct service staff.

For example, the group has an ongoing discussion to distinguish between the responsibilities of providers in clinical assessments and treatment planning vs. the responsibilities of the MCOs in HRAs and care coordination. Another ongoing discussion concerns credentialing and billing by peer support workers. The frequent meetings with MCO managers and agency CEOs facilitate effective communication through the resolution of such issues.

Pharmacy
Soon after implementation, it became clear that HSD needed to put in place a proactive process to focus on pharmacy issues. For example, HSD identified that pharmacy claims were being denied due to eligibility requiring overnight download from ASPEN to Omnicaid (Medicaid Management Information System [MMIS]), then the assignment of a member to an MCO taking an additional 48-72 hours to download from MMIS to the assigned MCO. Due to these delays, the MCO was contacted and directed to provide immediate eligibility for prescription coverage.

HSD quickly identified pharmacy issues and resolved issues in a timely manner. The following are examples of pharmacy issues that were identified and actions taken to resolve identified issues:

• There was confusion regarding FFS claims that should have been MCO claims. System edits were placed in the MMIS to address this issue.
• Coverage for nutritional products as well as required PAs for durable medical equipment (DME) products has been confusing for some providers and members requesting such items. HSD pharmacists quickly researched these issues and resolved them by contacting the member, provider and/or MCO when appropriate to be sure that no member lacks sufficient quantities of medical equipment or pharmaceutical products. These types of requests are top priority for response.
• A physician was concerned about the amount of PAs required for behavioral health medications. The MCO was contacted and directed to communicate with the physician to explain the requirements needed for medication requests. Some behavioral health medications continue to require PAs and the MCO formularies are currently being reviewed to assess the need for PAs.

MCO Reporting Process
The MCO reporting process involves the submission of monthly, quarterly, semi-annual, annual, and ad hoc reports to HSD. All combined, there are 96 reports each MCO is required to submit to HSD.

HSD’s process for tracking MCO report submissions is as follows.
The intake team consists of three intake staff and one administrative support person. The intake staff conducts the initial review of each MCO submission tracking timeliness, completeness (ensuring there is no missing data), and accuracy. Incomplete or inaccurate reports are rejected and the MCO is required to resubmit within 10 business days.

After conducting the initial review, the intake staff assigns the report to program, administrative, or technical staff for review and recommendation. The “reviewer” completes the review (utilizing HSD’s review tool) and submits recommendations to the intake staff, who then notify the contract managers that the report and recommendation is ready and available for final review. For each report, all reviews are consolidated into one review tool and forwarded to the MCO as an acknowledgment (no further reporting required), rejection (resubmission required), or general recommendations for future reporting. The intake team is responsible for ensuring the integrity of the reports (data), recommendations, and HSD’s final determination.

All data are monitored through HSD’s contract monitoring tool which tracks and trends MCO report submission dates, timeliness, rejections, and resubmissions. The contract monitoring tool contains associated dashboards which provide a visual interface (snapshot) of key measures relating to contract compliance.

Review tools have been developed for monthly and quarterly report submissions to guide reviewers in providing a thoughtful and thorough review. HSD’s reviewers are staff members who are highly competent in their respective roles as subject matter experts (i.e., program staff, medical and behavioral health professionals, and fiscal and systems professionals). Review tools are designed to align with specific sections of the reports and include a segment where the report reviewers identify areas of concern and determine if all or a portion of the reported data requires that it be escalated to management for further review and imposition of sanction or corrective action.

HSD is now turning its efforts to evaluating the effectiveness of its report review process. A five step process will be implemented by June 30, 2014.

1. Conduct analysis of process
2. Discuss lessons learned/identified issues (with those who participate in the process
3. Convene workshops on effective report review, including identifying relevant issues, determining trends, etc.
4. Make changes to the process
5. Leverage knowledge/implement changes

Throughout readiness and implementation HSD monitored MCO readiness and compliance through ad hoc as well as regular reports. The following grid shows the weekly ad hoc reports that have been required from pre-Centennial Care readiness review (2013) through implementation. All recurring reports were updated at least through the first quarter of 2014.
These reports were essential tools in the monitoring of MCO readiness and first quarter Centennial Care implementation/performance.

**Weekly Status Update Ad Hoc Reporting**

<table>
<thead>
<tr>
<th>Number</th>
<th>Name of Report</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>GeoAccess</td>
<td>To ensure the integration of behavioral health and long-term care providers in each MCO’s provider network and to monitor the progress of each MCO’s contracting given the unique challenges for rural and frontier access to care.</td>
</tr>
<tr>
<td>2</td>
<td>CSA Contracting Status</td>
<td>CSAs provide the majority of behavioral health services in clinic settings. To ensure that each MCO contracted with each approved CSA as required in the Centennial Care contract.</td>
</tr>
<tr>
<td>3</td>
<td>Provider Network Contracting Status</td>
<td>To ensure the integration of behavioral health and long-term care providers in each MCO’s provider network and to monitor the progress of each MCO’s contracting given the unique challenges for rural and frontier access to care.</td>
</tr>
<tr>
<td>4</td>
<td>Care Coordination Staffing Levels</td>
<td>To ensure the adequacy of each MCO’s care coordination function which is integral to Centennial Care.</td>
</tr>
<tr>
<td>5</td>
<td>Indian Health Service, Tribal Health and Urban Indian Health Providers (I/T/U) Contracting Status</td>
<td>To monitor MCO contracting and provide oversight with MCO relationship building with I/T/U facilities.</td>
</tr>
<tr>
<td>6</td>
<td>EVV Contracting Status</td>
<td>To ensure that each MCO is contracted with the EVV vendor in order to ensure the EVV initiative is implemented on schedule.</td>
</tr>
<tr>
<td>7</td>
<td>Member Rewards Contracting Status</td>
<td>The structure of New Mexico’s Member Rewards program is unique in the nation. The MCOs collaborated with HSD in its design. The contracting status reports from the MCOs helped HSD monitor the progress of this essential program.</td>
</tr>
</tbody>
</table>

In addition, HSD requested various non-recurring ad hoc reports from the MCOs as needed for monitoring performance.

**Electronic Visit Verification**

MCOs are contractually required to collaborate and contract with a vendor to implement an EVV system to monitor member receipt and utilization of the Centennial Care community benefit. MCOs have contracted with First Data to implement the EVV system, AuthentiCare®. The EVV system initiative will enable more accuracy in service tracking, reporting and billing for in-home care providers. The EVV system will allow MCOs and the provider community to better serve Medicaid members and ensure members receive the services they need.

**The EVV System Will:**
- Use landlines and/or GPS enabled mobile devices to track visits
- Be web-based and paperless
- Allow the provider to review the claim before confirming it for submittal
• Generate claims automatically
• Give providers the ability to create reports and report templates
• Provide real-time service information to providers and care coordinators
• Require access to the internet

**How the EVV System Will Work**
• Personal care services will be authorized for a member.
• The agency employee will arrive at the member’s home to provide personal care services.
• The employee will check into the AuthentiCare® system using the member’s land line or the employee’s smart phone to call a toll-free phone number. Additional options will be available if the Member does not have a land line or the employee does not have a smart phone. The employee will then enter their employee ID number and appropriate service codes.
• Caller ID or geo-location will be used to validate the location from which the call is placed.
• A database of pre-authorized services will be referenced to verify that the service has been pre-authorized.
• The employee will perform the service.
• The employee will check out using the same process.
• Claims will be available for the provider’s review through the AuthentiCare website.
• After the provider’s review, the provider will confirm the claim.

**Benefits**
• Will reduce manual work and paper processes
• Will streamline processes
• Will improve efficiencies
• Will improve the accuracy of data
• Will improve member care
• Will reduce potential for fraud
• EVV system will be accessed through the internet; purchase and installation will not be required

**Training**
Providers will send an agency billing staff, member and worker supervisor, and trainer for a full day of training with First Data to learn how to use the EVV system and train other employees in the agency. The following training dates and locations have been established:

• May 22, 2014 in Farmington, New Mexico
• May 27, 2014 in Albuquerque, New Mexico
• May 28, 2014 in Albuquerque, New Mexico
• May 29, 2014 in Albuquerque, New Mexico
• June 2, 2014 in Las Cruces, New Mexico
• June 3, 2014 in Las Cruces, New Mexico
• June 4, 2014 in Las Cruces, New Mexico
Providers, MCOs and HSD are working together to ensure EVV implementation is not disruptive to members and caregivers. This partnership will ensure a successful implementation of EVV, improving the member’s access to care and quality of care.

**Quality of Care**
The care coordination model is new to New Mexico Medicaid and central to Centennial Care. This process is being monitored closely for each MCO as they contact their membership to conduct HRAs, CNAs as necessary, comprehensive care plans (CCPs) and determinations of nursing facility levels of care. MCO staffing for their care coordination function is closely monitored against their membership who have been identified as requiring care coordination.

No quality of care issues have been identified by HSD in this reporting period.

**Approval and Contracting With New Plans**
At this time, there are no plans to contract with new MCOs.

**Health Plan Contract Compliance and Financial Performance Relevant to the Demonstration**
Regular reporting by the MCOs is required by the contract. Three months of regular reports have now been received. The first sets of quarterly reports were received at the end of April 2014. Each report is reviewed by subject matter experts for completeness, accuracy, timeliness and meeting contract specified metrics. The contract permits penalties and sanctions for MCOs failure to meet any of contractual requirements. We have identified systems issues and have developed workarounds for the identified provider types.

Based upon individual identified issues and on data received to date in reporting, it has been noted that some categories of providers are having difficulty with billing and the MCOs are having difficulty in paying some categories of providers/services. This appears to be related primarily to those providers and services new to Centennial Care such as long-term care, personal care service agencies, support brokers and behavioral health services.

To date, one Centennial Care MCO has been sanctioned for performance deficiencies. An initial sanction on 12/30/13 terminated the MCO from the member auto-assignment process. On February 28, 2014, PHP was notified of sanction for:

- Failing to submit accurate transition report data for month of January 2014
- Failing to meet contractual call center service levels
- Failing to meet adequate provider network for nursing facility services in Eastern New Mexico
- Failing to assign transitioning members from legacy Medicaid programs to care coordination levels in a timely manner
- Violating HIPAA requirements by sending unencrypted email communication seven separate times
Fiscal Issues
There are currently no fiscal issues that would be considered significant enough as to affect health care delivery under Centennial Care. During this reporting period, HSD made MCO capitation payments for only three months and is just now beginning to receive reliable encounter data. Therefore, financial analysis for this quarter is somewhat limited. HSD is, however, analyzing enrollment data and has seen a slightly higher than expected enrollment in the Parents and Caretakers eligibility group (Population/MEG 1 – TANF and Related). HSD is watching this enrollment shift closely to be able to predict costs during the first years of the waiver and to determine the overall impact on the Medicaid budget.

System Issues
There have been system issues that are expected with any major implementation. The legacy eligibility system, ISD2, was replaced by ASPEN beginning with a pilot wave in July 2013. ASPEN was implemented statewide in January 2014. With ASPEN, ACA and Centennial Care implementation all coinciding with each other, there have been associated system issues. The system issues have not been solely related to the implementation of Centennial Care but the interaction of implementing multiple initiatives at the same time. We have diligently worked to resolve any issues that have been identified in the initial quarter of Centennial Care.

Pertinent Legislation
In the 2014 NM Legislative Session, legislation implementing a voluntary statewide Community Health Worker (CHW) training and certification program was signed by Governor Martinez. A Board of Certification will be created and the Board will establish requirements and standards for certification, including a required criminal background check. The Centennial Care MCOs are contractually required to use these types of providers to increase member access to community resources and improve health outcomes, especially in rural and frontier areas of the State. The Board, training, and certification program will be administered by the New Mexico Department of Health.

Litigation
There have been no issues related to litigation at this time.

Quality Assurance/Monitoring Activity
Care Coordination
During the transition period, MCOs are required to complete the HRA within 30 calendar days of the new member’s enrollment. For all transitioning members (in Medicaid prior to 1/1/14), MCOs are required to complete the HRA and, if required the CNA and CCP within 180 calendar days following the member’s enrollment with the MCO.

The status of that effort is reflected in the table below. As the numbers show, the MCOs have faced unanticipated challenges in locating and engaging members in order to complete the HRA. HSD is tracking the unreachable members count very closely as well as the efforts the MCOs are
making to find them. Some of these efforts include use of contractors such as LexisNexis® to confirm contact information and using claims data. HSD will convene the MCOs in the next six weeks to develop a unified plan to find the unreachable members.

A result of the MCOs’ difficulties reaching their members is delays in conducting CNAs. In addition, some technical difficulties at HSD slowed the ability of the MCOs to conduct CNAs. HSD has provided the MCOs with two extensions for renewing the LOC for those members with expired or soon to expire LOCs. This has allowed the MCOs more time to locate their members and avoid disruption in services.

HSD monitors MCO care coordination activities to assure that sufficient care coordination is being delivered. HSD takes any necessary steps to ensure effective corrective actions are being implemented by the MCOs when needed. HSD staff also oversees care coordination through weekly technical assistance calls with the MCOs.

Challenges were encountered with one MCO being unable to operationalize and utilize their new care coordination system. As a result, data was unable to be uploaded from HSD and into their care coordination system. The MCO lost valuable time with the delay of this system implementation. It was unable to conduct in-home assessments and complete nursing facility LOC determinations in a timely manner. The MCO has since operationalized its system and it appears to be running smoothly. HSD continues to monitor progress and provides the MCO with ongoing weekly technical assistance in reducing the number of pending assessments.

Another MCO discovered that its HRA was assigning members to a higher LOC coordination than was indicated. The MCO discovered this after several CNAs were administered which resulted in the members being more healthy than reported. The MCO has since modified its HRA to reduce the number of these incidents.

HSD created a CNA exception process for the MCOs to request a waiver to the requirement that all CNAs be conducted in the member’s home. Each MCO must request a waiver from HSD to this requirement in order to conduct the CNA in an alternate location. HSD has received a total of 64 requests; five of those were denied. Most requests are because the member is transient or has behavioral health issues and is temporarily institutionalized out of state.

Some nursing facilities experienced difficulties identifying who their residents’ care coordinators were. Each MCO was directed to send its list of care coordinators with their contact numbers to the nursing facilities.
HRAs and CNAs completed as of 5/7/14

<table>
<thead>
<tr>
<th>Care Coordination</th>
<th>BCBS</th>
<th>Molina</th>
<th>PHP</th>
<th>UHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>HRAs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># HRAs completed for new members</td>
<td>19,097</td>
<td>8,523</td>
<td>2,646</td>
<td>6,976</td>
</tr>
<tr>
<td># HRAs completed for transitioning members</td>
<td>22,740</td>
<td>47,284</td>
<td>27,822</td>
<td>10,896</td>
</tr>
<tr>
<td># Unreachable members</td>
<td>12,461</td>
<td>72,482</td>
<td>77,223</td>
<td>16,685</td>
</tr>
<tr>
<td>CNAs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># CNAs required</td>
<td>9,904</td>
<td>14,353</td>
<td>2,483</td>
<td>15,106</td>
</tr>
<tr>
<td># CNAs completed</td>
<td>4,082</td>
<td>5,513</td>
<td>2,132</td>
<td>8,368</td>
</tr>
</tbody>
</table>

The MCOs continue working to meet and comply with the staffing ratios outlined in the contract. HSD monitors the monthly Caseload and Staffing Ratios Report designed to capture the overall care coordinator-to-member ratios. One of the challenges with the ratios is that they change as the MCOs progress in their completion of HRAs. Each completed HRA results in the assignment of the member to a care coordination level. The care coordinator-to-member ratio varies based on the care coordination level.

HSD has weekly meetings with the MCOs to address care coordination staffing requirements and performs a weekly care coordination staffing analysis. MCOs are actively recruiting, holding job fairs, and making every attempt to ensure ratios are within the outlined contract requirements, including assigning caseloads to care coordination supervisors and managers.

The tables below reflect the average number of care coordinators that need to be hired based on the MCOs total membership as of May 7, 2014.
### MHP Care Coordinators: Hired / Required, 2014

<table>
<thead>
<tr>
<th>Month</th>
<th># CCs Needed to Meet Required</th>
<th># CCs Hired</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feb</td>
<td>91</td>
<td>338</td>
</tr>
<tr>
<td>Mar</td>
<td>122</td>
<td>397</td>
</tr>
<tr>
<td>Apr</td>
<td>187</td>
<td>401</td>
</tr>
<tr>
<td>May</td>
<td>20</td>
<td>475</td>
</tr>
</tbody>
</table>

### PHP Care Coordinators: Hired / Required, 2014

<table>
<thead>
<tr>
<th>Month</th>
<th># CCs Needed to Meet Required</th>
<th># CCs Hired</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feb</td>
<td>-101</td>
<td>303</td>
</tr>
<tr>
<td>Mar</td>
<td>36</td>
<td>304</td>
</tr>
<tr>
<td>Apr</td>
<td>25</td>
<td>313</td>
</tr>
<tr>
<td>May</td>
<td>25</td>
<td>315</td>
</tr>
</tbody>
</table>
Eligibility/Enrollment

New Mexico’s new eligibility system, ASPEN replaced the legacy eligibility system and like any other complex new system, it experienced some issues. The issues included members being enrolled into incorrect categories of eligibility or having their eligibility closed due to missing nursing facility LOC data. These issues affected both the community benefit members and the institutionalized members. Members did not experience loss of services when this occurred.

The interface between the ASPEN system and the MCOs did not operate smoothly after implementation. This interface was designed for ASPEN to notify MCOs that LOCs needed to be performed and to allow the MCOs to send LOC approvals back to ASPEN. The State developed a manual workaround while the interface was being fixed. The interface is currently operating but some issues remain and are being addressed.

Nursing Facility Level of Care

Turnaround times for LOC approvals for community benefit members and nursing home residents have been delayed. HSD has dedicated staff working directly with providers and MCOs to troubleshoot and improve turnaround times. HSD has held four meetings with the New Mexico Health Care Association (NMHCA), the providers, and the MCOs to discuss concerns with LOC determinations, contracting and claims issues and develop next steps for resolutions. These meetings will continue. The NMHCA Director continues to meet with the individual MCOs regularly to address concerns regarding timely payment, LOC approvals and contract negotiations. HSD conducts weekly technical assistance calls with the MCOs’ program staff to help move applications and LOC determinations forward.
The MCOs’ LOC determinations are under a dual review process. HSD’s External Quality Review Organization (EQRO) conducts ongoing random reviews of LOC determinations to ensure that the MCOs are using the New Mexico criteria, process and tools consistently. The focus is on ensuring that the MCOs apply the criteria consistently across the population and that the members met the requirements for services. In addition, HSD/MAD Quality Bureau (QB) randomly reviews denials to ensure that they were appropriate based on the requirements.

During this reporting period, 403 LOC determinations were reviewed by the EQRO. The emphasis of the review was to ensure the correct process and tools were used to make LOC determinations. The correct process includes physician review for denials and downgrades, and the correct tools include the LOC criteria and protocol.

Quality Bureau gives the MCOs technical assistance and direction based on concerns identified by the EQRO findings. For example, the EQRO found a determination that requested and received LNF payment that met HNF criteria. QB reviewed the determination and found it did meet HNF criteria. The MCO was consulted and agreed that the member met HNF requirements. QB is revising the LOC policy to ensure that MCOs fully and accurately make determinations based on the medical documentation and not the level requested by the nursing facility.

Provider Issues
HSD met with the Executive Director of the New Mexico Association for Home and Hospice Care (NMAHHC) and its providers on two separate occasions to discuss issues that the provider community was facing due to some of the changes in processes implemented with Centennial Care, as well as payment issues. After these meetings, the provider community communicated to the State that they had arranged for regular ongoing communication with the MCOs to ensure smooth operations. This arrangement appears to be working well but HSD continues to contact the NMAHHC Executive Director on a regular basis to ensure no new issues are being identified.

HSD continues to work with community benefit providers to help reconcile any outstanding payment and claims issues. The MCOs issued advance payments to providers that were in dire financial situations to ensure that they were able to meet their payroll obligations.

Service Plans
The HSD/MAD Quality Bureau is reviewing all service plan reduction requests for the first six months of CC. The MCOs must submit all service plan reduction proposals to the QB for review and approval before the reductions can take place.

During this reporting period, seven reductions were requested by the MCOs. After review, the QB approved two of these requests for reductions. The reductions were approved because the members no longer met the minimum requirements of two activities of daily living in order to receive long-term services and supports (LTSS).
The QB and the EQRO will continue to conduct annual service plan reduction reviews to ensure that the MCOs are consistently using approved tools to determine member services and are following the process for assessing member’s needs.

The QB is randomly reviewing all service plans to ensure that the MCOs are using the correct tools and processes to create service plans. The review of the service plans also ensures that the MCOs are appropriately allocating time and implementing the services identified in the member’s comprehensive needs assessment. The review ensures that the member’s goals are identified in the care plan.
Section VII: Home and Community Based Services (HCBS)

Independent Consumer Support System (ICSS)
HSD is creating a streamlined tracking system that will inform the ICSS and support the reporting requirements to CMS. As the ICSS continues to establish a system of organizations that provide standardized information to beneficiaries about Centennial Care, LTSS, the MCO grievance and appeals process, and the fair hearing process, HSD will have access to a larger pool of data that will assist in understanding the types of questions and issues Centennial Care members may have when utilizing LTSS and whether the ICSS is meeting its intended purpose.

The ICSS reporting for the first quarter comes from the New Mexico Aging and Long Term Services Department (ALTSD), Aging and Disability Resource Center (ADRC). The ADRC is a single point of entry for older adults and people with disabilities looking to access information and services available in New Mexico. The ALTSD provides quarterly reports to HSD regarding their Care Transitions Program Data and ADRC Caller Profile Report. The numbers below reflect calls made to the ADRC hotline from January 1 to March 31, 2014.

ADRC Call Profiler Report

<table>
<thead>
<tr>
<th>Topic</th>
<th># of Calls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home/Community Based Care Waiver Programs</td>
<td>2,649</td>
</tr>
<tr>
<td>Long-Term Case/Care Management</td>
<td>102</td>
</tr>
<tr>
<td>Medicaid Appeals/Complaints</td>
<td>109</td>
</tr>
<tr>
<td>Personal Care</td>
<td>101</td>
</tr>
<tr>
<td>Transitional Case/Care Management</td>
<td>96</td>
</tr>
</tbody>
</table>

The numbers below reflect counseling services provided by the ADRC Care Transition Program as of March 31, 2014.

ADRC Care Transition Program Report

<table>
<thead>
<tr>
<th>Counseling Services</th>
<th># of Hours</th>
<th># of Nursing Home Residents</th>
<th># of Contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transition Advocacy Support Services</td>
<td>37</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid Education/Outreach</td>
<td>98</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid Options/Enrollment</td>
<td>436</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre/Post Transition Follow-up Contact</td>
<td></td>
<td>508*</td>
<td></td>
</tr>
</tbody>
</table>

*59% of the contacts are pre-transition contacts and the remaining 41% are post-transition contacts. These numbers are resident specific and situation dependent.

Critical Incidents
HSD operates a web-based critical incident reporting system to receive, track and trend critical incidents occurring within the HCBS populations and recipients receiving behavioral health services. Providers of Centennial Care services, including HCBS; long-term care, and self direction are directed to establish access to this system and to report incidents into the system within 24 hours of knowledge of the incident. Providers are also directed to report to New
Mexico Adult and Child Protective Services issues involving Abuse, Neglect and Exploitation (ANE).

This web-based system has the capability of maintaining ongoing clinical notes for each report, allowing the reporting agency and the MCO as well as HSD to monitor and report follow-up for those reports that require additional information or investigation. The MCOs are required to ensure the health and safety of the member who has an incident. HSD monitors the activities of the MCO and the agency to ensure appropriate actions are taken.

The required report #36 a & b (Critical Incidents) is completed and submitted monthly and quarterly. The web-based system is the data source for this report data (#36a) and the analysis report (#36b) is derived from the data. HSD reviews the submitted reports to verify the accuracy of the data and to ensure HSD has a comprehensive picture of critical incidents across the four MCOs and across the populations.

The following are activities that the HSD Critical Incident Unit engaged in the first quarter with respect to monitoring the performance of the MCOs and the service provider agencies:

• Ongoing bi-weekly meetings with the four MCOs to discuss issues and concerns about the process of reporting, system issues with the web based application, ongoing dialogue around interpretations of state expectations, provider issues, and other concerns that come up both at an individual member level and broader system levels.
• Daily review by HSD staff of incidents submitted. Issues about incorrect reporting, inadequate information or requests for specific follow up with egregious situations are addressed with the respective MCO.
• Weekly and monthly aggregated reports of concerns are emailed to each MCOs who responds with sufficient information to ensure HSD, the MCOs and agencies are doing due diligence.
• Monthly review by HSD staff of all deaths. HSD nurses review complicated cases. The MCOs are required to provide any information that is lacking in the incident notes. The HSD medical officer is available to consult on mortality cases and complex cases.
• Daily responses by HSD staff for password creation or resetting and for trouble shooting application issues, deleting duplicate reports and other business of operating the site.
• Ongoing collaboration with the HSD BHSD, and the HSD/MAD Centennial Care Bureau to address individual and system/program issues.

Currently the web-based system supports over 1000 users statewide. From January 1, 2014 to March 31, 2014, the data base managed more than 2,288 reports.
The following table reports specific data collected in the first quarter of Centennial Care.

<table>
<thead>
<tr>
<th>Critical Incident Types</th>
<th>Centennial Care</th>
<th>Behavioral Health</th>
<th>Self Directed</th>
<th>Total Number of Critical Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse</td>
<td>227</td>
<td>70</td>
<td>20</td>
<td>2125</td>
</tr>
<tr>
<td>Neglect</td>
<td>169</td>
<td>12</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Exploitation</td>
<td>81</td>
<td>1</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Environmental Hazard</td>
<td>41</td>
<td>1</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Emergency Services</td>
<td>1223</td>
<td>56</td>
<td>176</td>
<td></td>
</tr>
<tr>
<td>Law Enforcement</td>
<td>115</td>
<td>48</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Elopement/Missing</td>
<td>17</td>
<td>14</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Natural/Expected</td>
<td>190</td>
<td>8</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Unexpected</td>
<td>58</td>
<td>5</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Homicide</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Suicide</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Total Number of Critical Incidents</td>
<td>2125</td>
<td>216</td>
<td>280</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Systemic Community Benefit Issues**

HSD, along with the MCOs, worked extensively with stakeholders, including individuals with disabilities, older persons, families, Independent Living Centers, advocates, nursing facility providers, HCBS providers, and other interested groups during the development and implementation of Centennial Care. Continued stakeholder input and feedback is essential to the success of the Centennial Care program. This is particularly important given the vulnerability of the aged and disabled population enrolled in Centennial Care.

Each quarter and when new providers are approved, HSD sends the MCOs a current list of approved Agency Based Community Benefit (ABCB) providers to ensure the MCOs only contract with providers that have been credentialed/re-credentialed by the State. Additionally, HSD analyzes and monitors the number of providers for the entire Centennial Care program through the quarterly network adequacy reports and a quarterly ad hoc report that lists the ABCB providers for each MCO.

HSD has reviewed the MCO ABCB provider lists for the last quarter and provided feedback and direction regarding identification of non-approved providers. MCOs were directed to not issue any ABCB service authorizations until those associated providers have obtained approval status from HSD.

**Self-Direction of Benefits**

For the first 120 days of Centennial Care, the Self-Directed Community Benefit (SDCB) membership consisted of 960 individuals who transitioned from the Mi Via waiver. The SDCB population is not expected to grow until the ABCB recipients have been enrolled in the ABCB for at least 120 calendar days; May 1, 2014 is day 121. HSD anticipates that the most likely recipients to switch to SDCB will be some of those who transitioned to ABCB from Personal Care Services under the CoLTS program (prior to January 1, 2014).
In the current reporting period, HSD SDCB staff have encountered situations where an incident of abuse/neglect was only noted in the SDCB member’s care plan but was not referred to the proper agency for investigation and follow-up; HSD has reminded the MCOs of their responsibility to be informed on how to properly report all critical incidents.

Grievances and appeals related to SDCB have been minimal which may be due to the MCOs being instructed by HSD not to decrease the amount of the Mi Via transitioning population budgets for the first year of Centennial Care.

Quality assurance monitoring activities include: ensuring all Mi Via waiver participants successfully transitioned into Centennial Care and the SDCB; working with the various entities related to unexpected changes in eligibility due to ASPEN issues; accurate setting of care coding; active/inactive status in the FOCosonline system that supports the SDCB; and Assisted Living Facility (ALF) services. Since ALF is only offered in the ABCB, those who transitioned from Mi Via to SDCB had a choice to make. If the member wanted to remain in the ALF, he/she would have to switch to the ABCB and transfer to a New Mexico Medicaid approved ALF provider or remain in the SDCB and the SDCB member would need to revise his/her SDCB care plan to no longer include the ALF service. HSD allowed an extension for members to remain in the ALF for 90 days past the expiration of the approved service for those individuals whose care plan expired between January 1, 2014 and April 30, 2014 in order to allow them to make the decision and act on that decision as appropriate.
Section VIII: AI/AN Reporting

Access to Care
All four MCOs met access to care requirements. Please see Section II for additional information on access to care.

Contracting Between MCOs and I/T/U Providers
I/T/U providers are not required to contract with Centennial Care MCOs in order to be reimbursed for services. HSD is monitoring contracting between the MCOs and the I/T/Us. Several MCOs have initiated contracts with most of the I/T/Us, and all MCOs are reimbursing I/T/Us in a timely manner and working to put additional contracts in place. HSD believes that contracts can help I/T/Us increase third party payments for services they deliver but are not covered in the OMB rate.

Ensuring Timely Payment for All I/T/U Providers
The MCOs are meeting their contractual prompt payment requirements for I/T/Us so no timely payment issues related to the implementation of Centennial Care have been identified. HSD is monitoring and assisting with payment issues related to Medicare crossover claims and eligibility and the implementation of ASPEN.

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

<table>
<thead>
<tr>
<th>MCO</th>
<th>Date of Board Meeting</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBS</td>
<td>March 26, 2014 – Albuquerque</td>
<td>Care coordinators should explain purpose of the HRA prior to asking questions. Hold future NAAB meetings in different areas of the State so rural/frontier members can attend.</td>
</tr>
<tr>
<td></td>
<td>17 participants</td>
<td></td>
</tr>
<tr>
<td>Molina</td>
<td>March 18, 2014 – Albuquerque</td>
<td>Hold future NAAB meetings in different areas of the State so rural/frontier members can attend. Offer Web Ex. Explain the process for getting DME through Molina. Reach out to I/T/Us and Tribes on care coordination and peer support services.</td>
</tr>
<tr>
<td></td>
<td>Five participants</td>
<td></td>
</tr>
<tr>
<td>PHP</td>
<td>March 17, 2014 – Albuquerque</td>
<td>Hold future NAAB meetings in different areas of the State so rural/frontier members can attend. Send invitations to NAAB meetings to Tribal Senior Centers. Arrange care coordination activities with Tribal community health</td>
</tr>
<tr>
<td></td>
<td>Six participants</td>
<td></td>
</tr>
</tbody>
</table>
representatives.

Arrange a tour of the Rust Medical Center with senior centers from Five Sandoval.

Include artwork from the Five Sandoval area Pueblos at the Rust Medical Center.

<table>
<thead>
<tr>
<th>UHC</th>
<th>March 4, 2014 - Albuquerque</th>
<th>Hold future NAAB meetings in different areas of the state so rural/frontier members can attend.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nine participants</td>
<td>Send out a listing of care coordinators in the State.</td>
</tr>
</tbody>
</table>

Two NATAC meetings were held in 2014 with the following issues and recommendations identified:

March 10, 2014 NATAC: Request for more simplified letters to be sent out to Medicaid recipients from HSD; request for number of Native American enrollment for each Tribal community; provide MCO/FFS enrollment numbers at each meeting; continue with ongoing agenda items of access to care, payment for services, and behavioral health services under Medicaid.
Section IX: Action Plans for Addressing Any Issues Identified

The chart below describes all action plans implemented during the reporting period.

<table>
<thead>
<tr>
<th>MCO</th>
<th>Action Plan Name</th>
<th>Description</th>
<th>Date of Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>All MCOs</td>
<td>Unreachable Members</td>
<td>Based on lists of unreachable members submitted by all MCOs, HSD staff attempted to contact 25 members per week from each MCO for four consecutive weeks. HSD has plans to do innovative campaigns which would include booths at public spaces, member rewards for completing HRAs, coordinating with Income Support Division, school based clinics and other state agencies to facilitate reaching unreachable members. HSD has shared all enrollment files with the MCOs and has closely monitored the MCO’s activities toward decreasing the number of unreachable members.</td>
<td>03/10/2014</td>
</tr>
<tr>
<td>BCBS</td>
<td>UM Intake Line</td>
<td>Increase % of calls answered within 30 seconds for UM Intake during Centennial Care start up by optimizing schedules, reviewing Customer Advocate activities during peak call hours, and increasing employees.</td>
<td>2/14/2014</td>
</tr>
<tr>
<td>BCBS</td>
<td>Provider Tri County</td>
<td>Tri County reported that they were experiencing claims payment issues; HSD held weekly meetings for five weeks until the issues were resolved. HSD now touches base with the provider on an as needed basis.</td>
<td>2/25/2014</td>
</tr>
<tr>
<td>BCBS</td>
<td>CNA Revision</td>
<td>Revisions were made to the CNA template to facilitate a better member experience and to maximize efficiencies.</td>
<td>3/6/2014</td>
</tr>
<tr>
<td>BCBS</td>
<td>PCP Auto-Assignment</td>
<td>Correction to PCP Auto-Assignment logic to allow members 15 days to select a PCP prior to assigning one.</td>
<td>3/18/2014</td>
</tr>
<tr>
<td>BCBS</td>
<td>Community Benefit Services Plan Monitoring</td>
<td>A plan was developed to improve the results of review of the community benefit services plans by ensuring all care plan goals and safety and health needs were met. As part of the plan, system issues and barriers were identified and mitigated and a quality assurance process was implemented.</td>
<td>3/25/2014</td>
</tr>
<tr>
<td>Date</td>
<td>Description</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1/10/2014</td>
<td>Increase number of completed HRAs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1/13/2014</td>
<td>Increase number of CNA to meet contractual deadlines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1/14/2014</td>
<td>Reduce duplication of PAs to validate the daily Transition Report</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1/22/2014</td>
<td>Address performance standards/requirements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1/24/2014</td>
<td>Address high number of expired NFLOCs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2/11/2014</td>
<td>Increase required staffing to meet contractual guidelines for staffing ratios.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2/27/2014</td>
<td>Address completion of HRAs and CNAs for transitioning members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2/27/2014</td>
<td>Decrease the amount of members in UTC categories</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3/26/2014</td>
<td>Improve claims turnaround time for I/T/U's, day activity providers, assisted living providers, nursing facilities and home care agencies including community benefit providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHP HRA</td>
<td>Align internal resources to support HSD Transition Report data requirements driven by HSD Transition Report instructions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1/29/2014</td>
<td>PHP engaged an HRA vendor to augment its internal resources and ensure compliance with HRA contractual requirements. The vendor will begin executing HRA call campaigns; systems and processes will be aligned to ensure data integrity and reporting accuracy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHP</td>
<td>PA</td>
<td>Improve turnaround time (TAT) performance for UM/PA and PA backlog: The PA team was divided into teams with one handling everything from 1/30/2014 and the other team handling everything earlier, the backlog was up to date on 2/4/2014. Improve UM queue performance (Call Center): Call center set up 4 staff dedicated to the UM call lines in addition had 4 regular staff also answering the phones. In January call service level was at 50%, in February service level was at 87.2% and has met the contractual requirement every month thereafter.</td>
<td>1/29/2014</td>
</tr>
<tr>
<td>PHP</td>
<td>Nurse Advice New Mexico</td>
<td>Action Plan to address % of PHP Centennial Care calls answered within 30 seconds in order to achieve contractual requirements for call center performance.</td>
<td>1/24/2014</td>
</tr>
<tr>
<td>UHC</td>
<td>NurseLine not meeting operational metrics</td>
<td>Action plan implemented to reprioritize the calls from Centennial Care in the call tree which brought more agents into the queue.</td>
<td>1/9/2014</td>
</tr>
<tr>
<td>UHC</td>
<td>PCP auto assignment changes</td>
<td>Change/delay PCP Auto-Assignment process until the 16th day from eligibility load date for newly effective members that have not selected a PCP and exclude Native American members from PCP Auto-Assignment process.</td>
<td>1/3/2014</td>
</tr>
<tr>
<td>UHC</td>
<td>HRA completion</td>
<td>Increase member HRA completion rate for Level 1 enrolled members.</td>
<td>3/1/2014</td>
</tr>
<tr>
<td>UHC</td>
<td>LOC backlog</td>
<td>Identified nursing home members who have not had a LOC determination as initial or continued custodial stay.</td>
<td>3/31/2014</td>
</tr>
</tbody>
</table>
Section X: Financial/Budget Neutrality Development/Issues

The Centennial Care demonstration was implemented on January 1, 2014. HSD has made MCO capitation payments for only three months as of the end of the quarter (January – March 2014) and is just now beginning to receive reliable encounter data. Therefore, financial reporting for this quarter is limited.

HSD has implemented a new eligibility system, ASPEN, with implementation occurring over the course of Calendar Year 2013 and MAGI conversions occurring as of January 1, 2014. With the roll-out of ASPEN, HSD has seen some changes in the composition of the Medicaid member months compared to previous projections. In addition, retroactive enrollment has been at a much higher level than prior to January 1, 2014, as Medicaid applications for the first quarter continue to be processed. These initial programmatic transitions may impact the variance between quarter to quarter expenditures but should not have an impact on overall expenditure reporting or budget neutrality.

HSD has successfully begun reporting expenditures by MEG on the CMS-64. HSD anticipates that budget neutrality reporting will tie to the expenditure reporting on the CMS-64 on a quarterly basis. For the second quarter report, HSD will be better able to assess the data on enrollment and expenditures. HSD will continue to monitor, create and revise reports in order to have all necessary data for successful Section 1115 demonstration reporting.
Section XI: Member Month Reporting

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

<table>
<thead>
<tr>
<th>Eligibility Group</th>
<th>Member Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population 1 – TANF and Related</td>
<td>1,086,008</td>
</tr>
<tr>
<td>Population 2 – SSI and Related – Medicaid Only</td>
<td>116,149</td>
</tr>
<tr>
<td>Population 3 – SSI and Related - Dual</td>
<td>97,212</td>
</tr>
<tr>
<td>Population 4 – 217-like Group – Medicaid Only</td>
<td>6,731</td>
</tr>
<tr>
<td>Population 5 – 217-like Group - Dual</td>
<td>13,615</td>
</tr>
<tr>
<td>Population 6 – VIII Group (expansion)</td>
<td>321,237</td>
</tr>
<tr>
<td>Total</td>
<td>1,640,952</td>
</tr>
</tbody>
</table>
Section XII: Consumer Issues

A total of 469 member grievances have been filed by all the Centennial Care MCOs in the reporting period. Transportation ground non-emergency issues have constituted the largest number of concerns for recipients in each of the four MCOs. All MCOs have taken additional steps to resolve and decrease the number of transportation issues their members are experiencing by working closely with each of their respective transportation vendors. Urgent, routine, specialty and community benefit concerns have each constituted ≤9% of the total three highest grievance codes reported by the MCOs in the first quarter of implementation. Reports ranged from emergency room dissatisfaction with staff, long emergency room wait times, lack of same-day appointment availability for specialist and some requests were made to be assigned a different care coordinator or to change a personal care service provider. No significant trends have been evidenced in any areas reported through the grievance system outside of the trend related to transportation ground non-emergency.
Section XIII: Quality Assurance/Monitoring Activity

Please refer to section VI, for information on quality assurance and monitoring. No quality of care issues have been identified by HSD in this reporting period.
Section XIV: Managed Care Reporting Requirements

Network Adequacy
All four MCOs cover the entire area of New Mexico, a largely rural/frontier State. Access was monitored closely especially for those services that are new to some Centennial Care MCOs such as long-term care, personal care services and behavioral health services. It is noted that I/T/Us are not required to contract with the MCOs under Centennial Care and non-contracted providers are not considered when assessing access standards. However, Native American Centennial Care members may access services at I/T/Us at any time and the Centennial Care MCOs must pay I/T/U claims at the OMB rate with or without a contract.

HSD’s Centennial Care provider distance requirements for access to at least one provider are: urban counties, 90% of members within 30 miles; rural counties, 90% of members within 60 miles; and for frontier counties, 90% of members within 90 miles. One MCO was out of compliance regarding location of nursing facilities within the designated mileage standards for Quay (frontier) and Curry (rural) counties. The latest GeoAccess report indicates that this issue is now in compliance. The MCO is in compliance for the three county types: 96.5% access for urban counties, 97.5% for rural and 99.9% for frontier counties.

Customer Service
HSD contracts with the Centennial Care MCOs stipulate requirements for call center customer service. The contract standards are:

• Abandonment rate - <5%
• Answered in <30 Seconds – 85%
• Waiting Time <2 Minutes – 85%

For the reporting period, the average abandonment percentage for BCBS, Molina, PHP and UHC calls were <5% in all categories, except for the nurse advice line (NAL) and utilization management for the month of January. In January, the percentage was 6.25% for the NAL and 5% for UM. Corrective actions were put in place and percentages decreased to 2.5% in both categories in February. In March, the abandonment rates were 2.25% for the NAL and 2% for UM.

The average percentage of BCBS, Molina, PHP and UHC for calls answered in <30 seconds were <85% in member service, NAL, provider services and UM in January. Corrective actions were put in place and, as a result, the average rates increased to 89% - 93.5% in February and March, 2014.

During the reporting period, the standard of <2 minute wait time was met by all MCOs with average rates ranging from .15 – 1.00 minutes.
Appeals

There have been a total of 266 appeals filed by members for all four MCOs in the reporting period. Of the total appeals filed, 172 appeals (65%) have been upheld, 28 appeals (11%) have been overturned, and 65 appeals (24%) are pending resolution. All appeals have been addressed timely by the MCOs. Denial or limited authorization of a requested service has constituted 228 (86%) of the appeals filed. These have included requests for additional behavioral health inpatient days, requests for out-of-state providers, orthodontics and medications. In this reporting period, there has been no evidence of trends of appeals that have been filed or upheld or overturned by the MCOs.

Complaints and Grievances

186 reports (64%) of the total number of the three highest codes reported for member grievances by all the MCOs in the first quarter have been related to transportation. Issues have included early, late, and no pickups for appointments, arriving too early for scheduled medical appointments or having to wait too long following medical appointments. Additionally, concerns regarding appropriate accessibility of vehicles sent to pick up individuals for transport when requested in advance have been filed as concerns.

All MCOs are currently monitoring their transportation vendors closely to work toward resolution of these issues. MCOs are using daily, weekly and monthly meetings, reporting, and close monitoring along with applying corrective action plans as needed. Continued monitoring will occur over the next quarter by each MCO to determine effectiveness of interventions to decrease the number of transportation issues and grievances.

Other grievances filed in the first quarter of Centennial Care reporting constituting the highest codes reported, ranged from two reports (1%) each for pharmacy, provider specialist, MCO operational issues, to 27 reports (9%) related to emergency room use. Of the 292 highest reported grievances codes, no significant trends other than those related to transportation have been indicated while establishing the initial baseline reporting trends.

Critical Incident Reporting

The MCOs are successfully using the web based support system to collect, analyze and follow up with critical incident reports for their members per contractual requirement. The MCOs also ensure that ANE are reported to New Mexico Adult Protective Services (APS) and Child Protective Services (CPS) in a timely manner to ensure they can investigate as needed. Cooperation and collaboration between the MCOs and APS and CPS increases the opportunities for thorough investigations and more comprehensive follow up for health and safety. APS (and soon CPS) have access to the HSD database to keep all significant investigators informed.

Measures to Ensure Participant Protections

The MCOs are contractually required to ensure that all ANE incidents are reported to APS and CPS in a timely manner. This ensures those entities can investigate as needed. HSD monitors the
MCOs through the web site for the MCOs own follow up on the member’s health and safety with each incident. When HSD discovers that the MCO has not addressed the incident or sufficiently responded to the incident, HSD requests immediate follow up to be documented in the ongoing clinical diary of the incident. These reviews are real time and ongoing.

HSD, through policy and regulation, requires all in-home providers and caregivers that have direct access to members to have successfully completed a criminal background check. This is also included and verified through HSD’s community benefit provider credentialing process.
Section XV: Demonstration Evaluation

The evaluation of the Centennial Care 1115 demonstration waiver was submitted to CMS for approval in December 2013.

Currently, HSD is in search of an independent entity to carry out an evaluation of Centennial Care using the CMS approved Evaluation Design Plan as a guideline to ensure that Centennial Care is meeting its goals. The Request for Proposal (RFP) was issued Friday, April 18, 2014 and will close on Thursday, May 29, 2014. The timeline is as follows:

<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue of RFP</td>
<td>HSD</td>
<td>4/18/14</td>
</tr>
<tr>
<td>Acknowledge Receipt (of RFP) Form</td>
<td>Potential Offerors</td>
<td>4/30/14</td>
</tr>
<tr>
<td>Pre-proposal Conference</td>
<td>HSD, Potential Offerors</td>
<td>4/30/14</td>
</tr>
<tr>
<td>Deadline for Submission of Written Questions</td>
<td>Potential Offerors</td>
<td>5/7/14</td>
</tr>
<tr>
<td>Response to Written Questions</td>
<td>HSD</td>
<td>5/14/14</td>
</tr>
<tr>
<td>Deadline for Submission of Proposals</td>
<td>Offerors</td>
<td>5/29/14</td>
</tr>
<tr>
<td>Proposal Evaluation</td>
<td>Evaluation Committee</td>
<td>5/30/14-6/11/14</td>
</tr>
<tr>
<td>Selection of Finalists</td>
<td>Evaluation Committee</td>
<td>6/12/14</td>
</tr>
<tr>
<td>Best and Final Offers from Finalists</td>
<td>Finalists</td>
<td>6/17/14</td>
</tr>
<tr>
<td>Oral Presentations/Demonstration by Finalists (Conducted at HSD’s discretion)</td>
<td>Finalists</td>
<td>6/18/14—6/19/14</td>
</tr>
<tr>
<td>Negotiate/Finalize Contract</td>
<td>HSD and Finalist</td>
<td>6/20/14-6/27/14</td>
</tr>
<tr>
<td>Contract Award</td>
<td>HSD</td>
<td>7/1/14</td>
</tr>
<tr>
<td>Protest Deadline</td>
<td>HSD</td>
<td>15 days after contract award</td>
</tr>
<tr>
<td>Effective Date of Contract</td>
<td>HSD, Contractor</td>
<td>8/1/14 (retroactive to 7/1/14)</td>
</tr>
</tbody>
</table>
Section XVI: Enclosures/Attachments

- Attachment A: Budget Neutrality Tables (January 1, 2014–March 31, 2014)
- Attachment B: C4 Issues Chart
- Attachment C: Transition Report Template
### Section XVII: State Contacts

<table>
<thead>
<tr>
<th>HSD Staff Name and Title</th>
<th>Phone Number</th>
<th>Email Address</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Julie Weinberg</td>
<td>(505)827-6253</td>
<td><a href="mailto:Julie.Weinberg@state.nm.us">Julie.Weinberg@state.nm.us</a></td>
<td>(505)827-3185</td>
</tr>
<tr>
<td>Director</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSD/Medical Assistance Division</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nancy Smith-Leslie</td>
<td>(505)827-7704</td>
<td><a href="mailto:Nancy.Smith-Leslie@state.nm.us">Nancy.Smith-Leslie@state.nm.us</a></td>
<td>(505)827-3185</td>
</tr>
<tr>
<td>Deputy Director</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSD/Medical Assistance Division</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Matt Onstott</td>
<td>(505)827-6234</td>
<td><a href="mailto:Matt.Onstott@state.nm.us">Matt.Onstott@state.nm.us</a></td>
<td>(505)827-3185</td>
</tr>
<tr>
<td>Deputy Director</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSD/Medical Assistance Division</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angela Martinez</td>
<td>(505) 827-3131</td>
<td><a href="mailto:AngelaM.Martinez@state.nm.us">AngelaM.Martinez@state.nm.us</a></td>
<td>(505)827-6263</td>
</tr>
<tr>
<td>Bureau Chief for Centennial Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSD/Medical Assistance Division</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 Member Success Story 1
Member has many severe medical and behavioral health conditions. She has lived in poverty, been through abuse and trauma, and experienced homelessness several times in her adult life. Yet, she is a pleasant and soft-hearted person. Due to her condition, however, she is also a very vulnerable person.

In January, the member was evicted from the 3rd apartment in a matter of a year. Two personal care agencies now refused to provide services to her until her living environment was safe. She continued to attempt to live with her adult children or with people she considered trustworthy, but continued to have significant issues and instability.

When this member met her MCO care coordinator, the assessment was completed. The care coordinator immediately contacted the member’s PCP and began collaborating with the Nurse Practitioner and Community Support Worker. She was living in a safe place temporarily, but because of her living situation, she was not able to receive a few of her vital medications. Also, the person providing all of her support had numerous pervasive disabilities that would not permit her to care for the member long term. The physician explained that if her living situation did not stabilize so she could receive the medications, she would die within the year.

The care coordinator recommended a move to an Assisted Living Facility. With interest, the member and care coordinator began identifying options and visits to ALFs. She happily moved in one month later.

In short, our member went from a very dire and life threatening situation to a safe, happy and thriving life. She now receives all of her medications and personal care services, thus greatly improving her overall health and functioning. She is also safe from harm. She has met new people and enjoys the daily activity. Her life is transformed because her care coordinator, with knowledge of Centennial Care benefits and services, spent time with her, performed accurate assessments and collaborated with her team of providers to achieve this amazing outcome. All of this was done in just six short weeks. Member never stops saying “Thank you!”

Centennial Care Member Success Story 2
This member suffered complications after having a total knee replacement. His knee became infected and he was ultimately forced to have an above the knee amputation. Additionally, he needed two revisions post op to his stump.
The member’s world was now unfamiliar to him. He suffered memory loss from the trauma and medication side effects for pain and infection. Member now required total assistance and supervision for all activities of daily living. His once active lifestyle was now occupied with multiple therapies to relearn how to function with the prosthetic leg he now needed. His wife was always by his side. The couple is also the primary caregiver to their developmentally disabled son and to the member’s elderly mother-in-law whose health was declining. Member’s wife now found herself as the primary caregiver for three family members. She was overwhelmed, exhausted, and diagnosed with depression.

The MCO care coordinator conducted a CNA to determine needs. The MCO Healthcare Services Department approved the member for 19 hours of personal care services per week. The care coordinator was elated and quickly called the member’s wife to inform her of the approval. The wife’s tone of voice conveyed relief and joy at the news. She expressed her appreciation to the care coordinator. The member’s wife then asked “Are these 19 hours per month?” The care coordinator explained that the 19 hours were approved per week. The member’s wife then screamed with happiness and laughed uncontrollably at the news. Her jubilation and appreciation brought the care coordinator to tears.

Centennial Care Member Success Story 3
This member was referred to Hidalgo Medical Services for over utilization of the ER. The member was found to be going due to dental issues. A CHW worked with member to find an in network dental provider within the vicinity of member. A dental appointment made and the member went to the appointment. The member was informed that he needed a root canal performed. The member requested to be placed under anesthesia but the provider did not offer this option. The CHW searched the Dentaquest provider directory and called until a provider who does anesthesia was located in Albuquerque. An appointment was made, Logisticare (transportation vendor) was notified and member was transported to initial consultation. An appointment for the procedure was made but the provider needed a care taker to sign off once procedure was performed. The member has no family to accompany him to the visit. The CHW contacted Home Health Agencies to see if they are able to do this type of care. The CHW found an agency to assist with this. Member had procedure done and has not utilized the ER since.

Centennial Care Member Success Story 4
The MCO care coordinator was able to locate one of its members for the first time very recently. The member has been homeless and was previously incarcerated for an extended period of time. The care coordinator met with the member to complete the CNA. In the past two years since his release, the member has been receiving methadone maintenance treatment daily and has serious health issues including CHF, a recent blood clot, and has severe edema in his legs. His diagnoses also include bipolar disorder and PTSD. This is the first time he has had health insurance in most of his adult life. The care coordinator assisted him to connect to care and services through La Familia. He has severe sensitivity to light and the care coordinator helped him get special tinted
prescription glasses with minimal copayment. The care coordinator is also working with the member to access affordable housing.

At the end of our session he said he had never had anyone professional come out to see him where “he is” and work with him. He said this meant so much to him. He said he believed the care coordinator sincerely wants to help him and he thanked her multiple times and repeated how grateful he was. He was genuinely moved by the fact that a stranger from a giant healthcare company was truly interested in helping him make his life better.

**Centennial Care Success Story 5**

The Centennial Rewards website, catalog, and call center were all operational by the go-live date, January 1, 2014. Members could start earning credits for healthy behaviors on January 1, 2014 and redeem earned credits beginning March 31, 2014.

The first “healthy choices” activities for which members could earn rewards are:

- Healthy Smiles - annual dental check-up (Child and Adult)
- Healthy Babies – joining the MCO prenatal program
- Bone density testing

The quarterly report showed that the member rewards program is successful in that the most earned “Total Reward Dollars” were by Child Preventive Dental Services followed by Adult Preventive Services. Regular preventive care, early diagnosis and treatment can help avoid ER (emergency room visits) and more costly dental and other health problems that may develop or be worsened by lack of basic preventive care.