Centennial Care Waiver Demonstration

Section 1115 Quarterly Report
Demonstration Year: 2 (1/1/2015 – 12/31/2015)
Waiver Quarter: 2/2015

August 31, 2015
New Mexico Human Services Department

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Section I: Introduction

Launched on January 1, 2014, Centennial Care places New Mexico among the leading states in the design and delivery of a modern, efficient Medicaid program. Highlights from the first waiver year (January 2014-December 2014) include:

- Successful transition to Centennial Care;
- New benefits and features in Centennial Care;
- Improved care coordination;
- Expanded access to home and community-based services (HCBS);
- Centennial Rewards Program;
- Native American Technical Advisory Committee (NATAC) and Native American Advisory Boards (NAAB); and
- Addressing provider workforce issues and broadening access to care.

There are many initiatives in development during demonstration year two (DY2) that include:

- Creation of health homes targeted to persons with chronic conditions;
- Implementation of electronic visit verification that monitors member receipt and utilization of community-based services;
- Payment reform projects for both hospitals and other providers;
- Connecting jail-involved individuals who are being released with Medicaid and care coordinators in the Centennial Care program; and
- Expanding the use of community health workers through a pilot project.

Section II: Enrollment and Benefits

Eligibility
As noted in Section III of this report, there are 236,681 enrollees in the Expansion/Group VIII who are in Centennial Care. Growth in the expansion group shows 14,588 new enrollees for the second quarter (Q2).

Enrollment
Centennial Care enrollment indicates a decrease in all populations other than Group VIII. The expansion of Medicaid eligibility continues to be the factor contributing to the 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. Overall enrollment continues to increase each quarter.

Disenrollment
The New Mexico Human Services Department (HSD) continues to monitor disenrollment and any potential issues. Validation checks are run periodically to identify any potential gaps in enrollment. Any issues that are identified or reported are researched and addressed. The disenrollment numbers continue to decrease from quarter to quarter. There was an increase in the disenrollment of Group VIII this quarter but overall the disenrollment numbers have decreased. (See Section III: Enrollment Counts)

Significant work has been done to clarify the reasons for disenrollment for Centennial Care members. A notices workgroup was convened and has reviewed all notices sent to members. From this workgroup, it was determined that the Centennial Care disenrollment notice from the Medicaid Management Information System (MMIS) could provide more information to members regarding the reason for their disenrollment. HSD is implementing changes that will help to clarify the disenrollment reason(s) to members.

Access
Throughout this report, unless otherwise noted, the most current monthly data available is through May 2015. Quarterly data is available through the first quarter of 2015.

Primary Care Provider (PCP)-to-Member Ratios
The PCP-to-member ratio standard of 1:2000 was met by all Managed Care Organizations (MCOs) in urban, rural and frontier counties. There are no PCP concerns at this time.

Physical Health (PH) & Hospitals
Geographic access standards were met by all MCOs for general hospitals, federally qualified health centers (FQHCs), PCPs, pharmacies and most specialties in urban, rural and frontier counties. UnitedHealthcare (UHC) met all of the access standards in urban areas. Except for dermatology, the remaining MCOs met all of the geographic access standards for services in urban areas. Specialty services for which geographic access standards were not met by all MCOs

in rural and frontier areas include: certified midwives, hematology/oncology, dermatology, endocrinology, neurology, neurosurgeons and rheumatology. Please see Attachment B: GeoAccess PH Summary.

The one MCO that did not meet access standards for certified midwives in rural areas was Molina Healthcare of New Mexico (MHNM). MHNM provided geographic access for 88 percent of its members when 90 percent is the contract standard. MHNM notes; however, that there are two additional certified midwives available to its members in Lea County where the deficiency exists. These certified midwives are available through the HSD Birthing Options Plan, though they are not contracted with MHNM and are not, therefore, included in the GeoAccess report and access calculation.

The MCO that did not meet access standards for hematology/oncology in rural areas was Blue Cross Blue Shield of New Mexico (BCBSNM). On July 1, 2015, BCBSNM amended a contract with one of its medical groups, which includes hematology/oncology providers, to include Centennial Care. The medical group was previously contracted for commercial lines of business only. This medical group will add hematology/oncology provider access in Eddy, Lea and Chaves counties. BCBSNM anticipates that these providers will be included in the third quarter report submission, and that the MCO will meet geographic access standards in urban, rural and frontier areas for this specialty going forward.

All four MCOs are very close to meeting, or have met, the access standards for neurology. MHNM met the geographic access standards for neurology in rural areas, and BCBSNM met the standard for neurology in frontier areas. MHNM met the access standards for rheumatology in both the rural and frontier areas. MHNM met access standards for dermatology, and UHC met access standards for endocrinology in frontier areas.

Access issues are primarily remedied by providing member transportation to the nearest provider. Other options include telemedicine and single case agreements with out-of-network providers.

Long-Term Care
All MCOs met the geographic access standards for delegated personal care service (PCS) agencies, directed PCS agencies and nursing facilities (NFs) in urban, rural and frontier areas.

Transportation
All four MCOs met access standards for transportation services in urban, rural and frontier areas. With the combination of a clarification in report instructions and adding vehicles to its fleet statewide, UHC improved its access in frontier areas to 99 percent. UHC's internal action plan, to improve access to transportation remains open. See Section IX: MCO Action Plans.

Behavioral Health (BH)
Core Service Agency (CSA) Transition
La Frontera has worked with four New Mexico providers designated by HSD as CSAs to seamlessly transition members in seven counties. Hidalgo Medical Services (HMS), also an FQHC, transitioned core BH services for children and adults in Grant and Hidalgo counties on May 31, 2015 with the exception of Intensive Outpatient Program (IOP). Once the IOP application process is complete and approved, HMS will provide the service.

Presbyterian Medical Services (PMS) successfully transitioned all children and adult core BH services in Luna, Otero, and Lincoln counties on May 31, 2015. This included the Psychosocial Rehabilitation (PSR) program in Luna County. PMS will survey the Ruidoso community to determine viability and need of service not previously provided by La Frontera in Ruidoso.

Ben Archer, an FQHC, agreed to expand BH services to Sierra County. PMS also provides services in Sierra County. Both organizations provide children and adult services and are able to serve this county effective June 1, 2015.

The transition in Dona Ana County is underway. La Clinica de Familia (LCDF) will become a CSA providing children's and adults' core BH services. Treatment foster care (TFC) and children's shelter services will continue to be supported by La Frontera until LCDF is approved as a service provider by the New Mexico Children, Youth and Families Department (CYFD).

Medication Assisted Treatment and Intensive Outpatient Services
As of August 2015, 13 methadone clinics operate in New Mexico. Of the 13, nine currently accept Medicaid, two opened late 2014 and accepted Medicaid in the late summer of 2015, one began the Medicaid application process, and one clinic will begin the process by summer of 2015. Additionally, three new medication assistant treatment programs have been approved and their clinics should be open by the spring of 2016. As of August 2015, there are 18 Medicaid approved IOP programs and five applications pending approval.

Service Delivery

Applied Behavior Analysis Services
On May 1, 2015, the Applied Behavior Analysis (ABA) NMAC rule (8.321.2.10) went into effect. The new rule expanded the age limit for persons eligible for ABA services from under the age of five to under the age of 21. Six experienced ABA providers were granted provisional provider status until September 30, 2015. The new rule requires autism providers and practitioners to be Board Certified Behavior Analyst®(BCBA®) or Board Certified Behavior Analyst-Doctoral® (BCBA-D®) by the Behavior Analyst Certification Board (BACB®).

To assure members did not have a break in services, the provisional providers were given guidance about continuing to provide services to enrolled members, those who had reached age five, and those who had reached the previous utilization limit of 36 months. Providers were

directed to complete a Comprehensive Diagnostic Evaluation (CDE) and Integrated Service Plan (ISP) for any member who had gone three years since his/her last evaluation. Providers were also directed to develop waitlists to allow at-risk eligible recipients priority for stage 2 and 3 services prior to accepting eligible recipients who have completed their CDE and have an ISP recommending ABA stage 2 and 3 services.

An autism workgroup was formed to continue the work of the Autism Care Coordination Council (AC3). The AC3 studied the available services for members identified with Autism Spectrum Disorder (ASD) prior to the revision of NMAC regulation (8.321.2.10). Representatives from each MCO, CYFD, Department of Health (DOH), and HSD meet weekly to develop level of care guidelines and prior authorization forms to be used by all MCOs. The autism workgroup invites providers to meetings to help clarify services and provide feedback on documents to be used for prior authorization or level of care guidance. Representatives from the University of New Mexico Applied Behavior Analysis Program and Center for Developmental Disability (CDD) have attended workgroup meetings to provide information on the BCBA® program and training requirements.

PH Utilization Data

As reported in quarter one, the 2014 90-day annual supplements for the MCO Utilization Management Reports were submitted to HSD in April 2015; however, two MCO reports were rejected for inaccuracies and required resubmission. HSD directed the MCO to provide an action plan. HSD is also moving forward with extracting data from the MMIS data warehouse to replace some of the MCOs' utilization reports. Pharmacy data, which is reported independently from other utilization data, is attached. See Attachment E: 2014 Pharmacy Utilization.

Pharmacy

The average MCO pharmacy claim denials, as a percent of claims processed from January through May 2015, were: 18.2 percent for BCBSNM, 26.8 percent for UHC, 23.6 percent for MHNM and 19 percent for Presbyterian Health Plan (PHP). The overall average was 21.9 percent of the total claims processed. The first two months of the second quarter reflect a slight decrease in the percent of claims denied as compared to the first quarter of DY2. Out of the total claims processed, MHNM and UHC appear to have a higher number of members with medication overutilization which contributes to high denial rates. These claims are mainly denials for early refill, plan limits exceeded, and days' supply exceeds maximum. The denial reasons are used as monitoring tools to prevent members from over-utilizing medication. Other denial reasons ensure proper payment by the MCO when the claim is filled, including: before/after coverage is effective, national drug code (NDC) is not covered, and prior authorization is required. MHNM has provided supporting documentation for denial edits and the other MCOs have been asked to provide documentation for any denials that exceed 25 percent of their total monthly claims processed.

Table #1. January-May 2015, Denied Claims as a Percent of Total Claims Processed

	2015					MCO
	Jan	Feb	Mar	Apr	May	Average
BCBS	18.5%	18.5%	18.4%	18.1%	17.7%	18.2%
UHC	26.5%	26.5%	30.4%	24.9%	25.5%	26.8%
MHNM	22.8%	23.2%	24.4%	24.1%	23.5%	23.6%
PHP	19.4%	19.9%	19.3%	18.9%	17.7%	19.0%

Source: MCO Report 44 (Jan-May 2015)

The MCOs reviewed the new HIV antivirals (Prezcobix - Darunavir/Cobicistat, Evotaz - Atazanavir/cobicistat, and Vitekta - Elvitegravir) for addition to their formulary as outlined in HSD's Letter of Direction (LOD) 28 to cover Human Immunodeficiency Virus (HIV) drugs without requiring prior authorization. New, long-acting opioids with abuse-deterrent properties were reviewed, and formulary alternatives were recommended for coverage. All MCOs are appropriately managing their formularies based on clinical and economic value.

Expenditures for hepatitis C treatment continue to show Harvoni® as the most utilized therapy for Centennial Care members. Sovaldi, approved in December 2013, is the second most utilized drug based upon expenditures. HSD will continue to monitor hepatitis C treatments and will include utilization of new products like: Viekira Pak, Olysio (approved in November of 2013), and Telaprevir (approved in May of 2011), for the treatment of hepatitis C.

In the third quarter of 2014, the MCOs worked together on a hepatitis C treatment initiative. A common treatment request checklist was created to standardize the prior authorization review process for all the MCOs. HSD and a network of medical experts reviewed the checklist and made modifications to reflect standard of care based on evidence; reduce the administrative burden on the provider; and, promote standardization of the prior approval process across all MCOs.

Nursing Facilities (NFs)
A new Medicaid Institutional Care (IC) eligibility unit was established beginning in April 2015. All IC and waiver cases were transitioned from the HSD Income Support Division (ISD) eligibility field offices to this central location. HSD will monitor the effectiveness of this change.

Provider Network
Unique MCO initiatives include working with contracted provider networks to encourage appropriate medical screenings for its Centennial Care members. This includes a provider performance-based quality incentive pilot to begin in the third quarter of 2015. The evaluation and outcome of this pilot will help inform the comprehensive physician incentive plan. An incentive plan will be submitted at the beginning of the 2016 demonstration year as required by the contract. This provider incentive pilot for Centennial Care contracted providers will be effective on July 1, 2015 and will run through December 31, 2015.

Another payment reform initiative involves value-based contracts with providers. The MCO meets with providers monthly to review identified gaps in care and works with them to close the gaps. At six months, an interim report will be prepared and providers who have met their targets receive points. Points are tied to per member per month (PMPM) payments and the providers are reimbursed accordingly.

Video visits, as reported last quarter, were piloted for members to have a convenient and modern approach for treatment through a computer webcam or smart phone using a mobile app. Another MCO is in the process of implementing "Virtual Visits" for both Urgent Care and Behavioral Health visits through websites. After the launch of these websites, member communication and outreach efforts will be initiated. Services are secure following all medical privacy rules and regulations, and may help to reduce non-emergent visits to the emergency rooms (ER).

Another innovation which may reduce non-emergent visits to the ER, and is being implemented by more than one MCO, is a home paramedic program designed to proactively identify high ER utilizers and high risk members for readmissions following acute facility stay discharge. This service may include medication reconciliation and connectivity with PCPs and core coordination for members. It also has the added advantage of quick response and identification of obstacles to healthy living which can be addressed onsite and in a timely manner.

Centennial Rewards Program
The Centennial Rewards program has more than 407,000 members earning rewards, a 17.5 percent increase from the last quarter. At the end of DY2 Q2, members had accumulated $17.7 million in reward points and redeemed $2.1 million. The table below shows credits earned by activity.

Table #2. DY2 Q2 Credits Earned and Redeemed by Activity

Eligibility Activities	Reward Credits	Total Credits Earned by Activity	Total Credits Redeemed by Activity
Healthy Smiles for Adults	$25	$3,436,600	$382,560
Healthy Smiles for Children	$35	$8,668,800	$1,129,395
Step-Up Challenge	$50	$74,975	$49,200
Health Risk Assessment (HRA)	$10	$1,468,200	$74,180
Healthy Pregnancy	$100	$593,900	$89,517
Diabetes Management	$80	$2,226,640	$275,156
Asthma Management	$75	$426,015	$67,201
Schizophrenia Management	$75	$276,645	$29,721
Bipolar Disorder Management	$75	$509,340	$54,129
Bone Density Testing	$35	$18,270	$2,082
Other (Appeals)	N/A	$35,904	$20,842
TOTAL		**$17,735,289**	**$2,173,983**

Community Interveners

There are a total of seven Centennial Care members receiving community intervener services statewide. Community Outreach Program for the Deaf (COPD) reported a total of 248 units of community intervener services billed under Medicaid. This totaled $6,014.25 in claims for the first quarter of 2015. COPD anticipates continued expansion of community intervener services under Centennial Care across the State.

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 #3. Enrollment DY2 Q2

Demonstration Population	Total Number of Demonstration Participants Quarter Ending – June 2015	Current Enrollees (Rolling 12 month period)	Disenrolled in Current Quarter
Population 1 – TANF and Related	360,042	358,184	5,614
Population 2 – SSI and Related – Medicaid Only	41,472	42,264	749
Population 3 – SSI and Related – Dual	36,067	39,176	570
Population 4 – 217-like Group – Medicaid Only	226	287	70
Population 5 – 217-like Group – Dual	2,238	2,625	23
Population 6 – VIII Group (expansion)	236,681	277,642	8,228
Totals	676,726	720,178	15,254

Disenrollments

Disenrolled is defined as when a member was in Centennial Care at some point in the prior quarter and disenrolled at some point during that quarter or in the reporting quarter and not re-enrolled at any point in the reporting quarter. Members who switch MEGs are not counted as disenrolled. DY2 Q2 had a decrease of 2,534 disenrollments from the previous quarter.

Table #4. Disenrollment Counts DY2 Q2

Disenrollments	From DY Q1 to DY Q2		Disenrollments During DY2 Q2
LAST MONTH CLIENT WAS DISENROLLED	**April 1, 2015**	**May 1, 2015**	
Population 1 – TANF and Related	2,639	2,975	5,614
Population 2 – SSI and Related – Medicaid Only	238	511	749
Population 3 – SSI and Related – Dual	292	278	570
Population 4 – 217-like Group – Medicaid Only	33	37	70
Population 5 – 217-like Group - Dual	10	13	23
Population 6 – VIII Group (expansion)	3,867	4,361	8,228
Total Without MEG 7	7,634	8,893	15,254

Section IV: Outreach

HSD held two public meetings in Clovis and Farmington to announce the New Mexico health homes initiative, also known as CareLink NM that will be implemented early next year. This is the new Medicaid program for individuals living with serious mental illness or severe emotional disturbance that will integrate coordination of both behavioral and physical health care along with community services to improve quality of care and reduce health care costs. BH professionals, advocates, providers and patients attended these two town hall meetings where information about CareLink NM was shared. The attendees of these town hall meetings provided valuable feedback for CareLink NM plan development. HSD staff also held a CareLink NM meeting in St. Michael's, Arizona with Navajo Nation leaders to present the program and receive comments/suggestions for program development.

HSD is developing new Centennial Care brochures and informational materials in English and Spanish, and a separate brochure for Native American outreach. As part of this effort, MAD marketing staff visited 10 different ISD offices across New Mexico to develop marketing and outreach materials. HSD will design a Centennial Care poster to increase awareness of the program. HSD also produced a 12-minute video that highlights Centennial Care. Copies of this video will be distributed to all ISD offices across New Mexico.

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

All four MCOs are in production for all invoice types, professional, institutional, and dental. The MCOs submit encounters daily and/or weekly to stay current with their encounter submissions. HSD continues to respond to any questions and address any problems.

Data is extracted on a monthly basis to identify Centennial Care enrollment by MCO and for different populations. Any discrepancies that are identified, whether due to systematic or manual error, are immediately addressed. Eligibility and enrollment reports were developed and are run on a regular basis to ensure consistency and tracking of numbers. A dashboard tool was created for management to access encounters by MCO so that they can view encounter submissions across the four MCOs. HSD continues to monitor enrollment and any anomalies that may arise so that they are addressed and resolved timely.

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

Program Development

Unreachable Member Campaign
A Centennial Care member is determined to be unreachable when, after at least three attempts, the member cannot be reached by the MCO. Unreachable status does not affect a member's Medicaid eligibility.

The Unreachable Member Campaign results represent the MCOs' unique and innovative attempts to connect with their members. HSD has directed each MCO to improve its unreachable count by five percent each month. In all but one instance, the MCOs met their goals. MHNM, who did not meet its goal in April at 3.39 percent, improved to 9 percent in May, and 7.59 percent in June (see Table #5. below).

Table #5. Unreachable Member Campaign DY2 Q2

	Apr				May				Jun			
	Baseline	5% Target	Reached	Percent Improved	Baseline	5% Target	Reached	Percent Improved	Baseline	5% Target	Reached	Percent Improved
BCBSNM	13,223	661	905	6.84%	13,605	680	974	7.16%	12,455	623	1,097	8.81%
UHC	20,081	1,004	1,927	9.60%	18,438	922	1,304	7.07%	17,265	863	1,129	6.54%
MHNM	31,703	1,585	1,075	3.39%	31,842	1,592	2,866	9.00%	30,237	1,512	2,294	7.59%
PHP	52,579	2,629	7,102	13.51%	45,618	2,281	4,149	9.10%	43,309	2,165	4,877	11.26%
Source: MCO monthly reporting												

PHP reports that as part of its community health engagement and delivery system improvement efforts, it has increased its community health worker (CHW) contracted resources by over 50 percent. PHP states that these contracts allow them to increase member engagement for unreachable and high-risk members, increase member health knowledge and compliance (adherence to care plans and medication treatment), and improve member self-management skills with the goal of improving clinical outcomes.

Electronic Visit Verification (EVV)
The MCOs agreed to allow a temporary exemption for the "no tech zone" areas if an agency meets two of the following three criteria:

1. Have a primary office location in a county that has been defined by HSD as rural or frontier;
2. Attest, in writing, that more than 50 percent of the agency's total clients, or 80 clients in total (whichever is higher), live in no-tech areas; or
3. Attest, in writing, that the internet bandwidth speed at their primary office location is less than twenty megabits per second (mbps).

It should be noted that during the second quarter, personal care organization (PCO) advocacy groups approached HSD regarding limitations of the EVV devices currently offered by First Data. With more than half of the PCS providers meeting the no tech zone criteria, HSD and the MCOs are exploring additional or alternative technologies for solutions (e.g. global positioning systems (GPS)/HIPAA-compliant devices). Additional or alternative technologies might improve the percentage of PCS providers who are able to utilize the EVV system.

Behavioral Health Provider Training

Care Coordination
HSD, DOH, CYFD and PHP developed BH training for care coordinators. The training was delivered three times over the summer:

- June 29 at the PHP office in Albuquerque.
- August 13 at the La Clinic office in Las Cruces.
- August 20 at the La Casa office in Roswell.

The theme of the training was "Recovery and Resiliency". The training covered the following topics:

- Transition planning for children and adults.
- Discharge planning for children to adult services.
- Discharge planning for children and adults to another level of care.
- New ABA services.
- Family, Infant and Toddler (FIT) services.

Care coordinators were provided with resources that included CSA contacts and BH service definitions.

Attendance for the trainings was limited to 20 care coordinators per MCO. The popularity of the first training prompted scheduling the August trainings. Moving forward, the MCOs will use the training materials for internal care coordination trainings.

BH Providers
During May and June 2015, HSD offered BH providers training in Clinical Reasoning & Case Formulation, with an emphasis on application in treatment planning.

Originally, three trainings were planned. Six Continuing Education Units (CEUs) were issued to counseling and social work practitioners. The response was so popular that two additional trainings were delivered. Almost 100 practitioners representing children and adult serving agencies as well as substance abuse agencies attended the six-hour training. The dates and sites were:

- May 5 and June 25, Albuquerque
- May 7, Las Cruces
- May 29, Clovis
- June 24, Rio Rancho

Two of the trainings were on-site and customized to two CSAs who are transitioning BH members from departing providers. Additional trainings are scheduled for the Navajo Nation in September 2015.

BH Crisis Line (NMCAL)
The State's mental health crisis hotline, New Mexico Crisis Line (NMCAL) is scheduled to expand services beginning in July. The line is staffed by mental health professionals 24 hours, seven days a week, 365 days a year. In the first six months of 2015, NMCAL handled 7,853 crisis calls, and over 1,500 were connected to NMCAL by the National Suicide Prevention Lifeline.

Fiscal Issues
HSD is preparing to implement mid-year managed care rate adjustments which include rate adjustments for NF low-level rates, additional autism services to meet CMS requirements, and a new health exchange assessment. HSD and its actuary have also begun data analysis for demonstration year three (DY3) rate development for rates effective January 1, 2016. There is a substantial amount of rate development work around LTSS to fully assess recent transitions of members into the program.

HSD and its actuary have begun to review data for the hepatitis C risk corridor reconciliation. HSD and its actuary are reviewing the data for the first quarter of calendar year 2015. In addition to the hepatitis C reconciliation, HSD and its actuary have begun the retro period reconciliation reviews looking at data encompassing all of calendar year 2014. Both reconciliations have potential recoupments for both the Medicaid base population and Medicaid expansion population.

Systems Issues
In evaluating the nursing facility level of care (NF LOC) data, HSD has identified that there may be misunderstanding among the MCOs as to how to apply the NF LOC criteria accurately and therefore categorize the setting of care correctly. To address this issue, HSD will be conducting audits of the MCOs along with providing additional training based upon identified issues.

HSD is continuing to address the issues regarding patient pay amount differences between the MMIS and ASPEN. HSD has conducted research and analysis regarding this issue and identified that not all patient pay amounts are being sent from the eligibility system, ASPEN to the MMIS. There are discrepancies between the letters generated from ASPEN and patient pay amount in

the MMIS which causes confusion for NFs. To address these discrepancies, HSD is extracting reports from ASPEN and the MMIS to run comparisons and resolve the issue.

Section VII: Home and Community Based Services (HCBS)

New Mexico Independent Consumer Support System (NMICSS)

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

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

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

The numbers below reflect calls made to the ADRC hotline from April 1 to June 30, 2015.

Table #6. ADRC Call Profiler Report

Topic	# of Calls
Home/Community Based Care Waiver Programs	1,862
Long Term Care/Case Management	102
Medicaid Appeals/Complaints	31
Personal Care	1
Transitional Case/Care Management	183
State Medicaid Managed Care Enrollment Programs (New Topic beginning FY14 Q3)	0
Medicaid Information/Counseling (New Topic beginning FY14 Q3)	1,559

The numbers below reflect counseling services provided by the ALTSD Care Transition Program from April 1, 2015 to June 30, 2015.

Table #7. ADRC Care Transition Program Report

Counseling Services	# of hrs	# of Nursing Home Residents	# of Contacts
Transition Advocacy Support Services		148	
Medicaid Education/Outreach	1,388		
*Medicaid Options/Enrollment	114		
Pre/Post Transition Follow-up Contact			**1,595

*Care Transition Specialist team educates residents, surrogate decision makers and facility staff about Medicaid options available to the resident and assist with enrollment.

** Note: 77 percent of the contacts are pre-transition contacts and the remaining 23 percent are post transition contacts. These numbers are resident specific and situation dependent.

As a member of the NMICSS, the ALTSD Care Transition Bureau (CTB) provides assistance to Medicaid beneficiaries enrolled in Centennial Care receiving LTSS (institutional, residential and community based) in navigating and accessing covered healthcare services and supports. CTB staff serves as advocates and assists individuals with linking to both long-term and short-term services and resources within the Medicaid system and outside of that system. CTB staff also monitors to ensure that services identified as a need are provided by the MCO, MCO subcontractors and other community provider agencies. The main purpose is to help consumers identify and understand their needs and to assist them in making informed decisions about appropriate LTSS choices in the context of their personal needs, preferences, values and individual circumstances. The CTB has assisted 92 individuals during this reporting quarter.

Critical Incidents
HSD continues to work with the Critical Incident (CI) workgroup to finalize the BH CI incident reporting protocols for providers. The BH protocols will be used by BH providers to improve accuracy of information reported and to establish guidelines for the type of BH providers required to report.

CIs are being reported quarterly by each MCO. This data is trended and analyzed by HSD. The HSD CI Unit engaged in the following monitoring activities during the second quarter with respect to the performance of the MCOs and their provider agencies:

- Monthly CI workgroup meetings between MCOs and HSD to discuss issues and concerns about the CI reporting process.
- Daily review of incident reports is conducted by the MCOs and the HSD CI Unit. On a weekly basis, the HSD CI Unit identifies unaddressed issues in a report to the MCOs with a deadline for response to ensure the quality of reporting by providers and that the requirements for follow-up are met in a timely manner.
- 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 remains continuous.
- Internal collaborations continue to occur between the HSD CI Unit and other internal HSD staff. The HSD CI Unit shares relevant information with other State agencies when a system issue is identified.

A quarterly review of all deaths submitted through the HSD CI web portal is conducted. HSD clinical staff reviews decedent data and consults on mortality cases, quality of care and complex cases. There were a total of 341 reported deaths: 290 were expected deaths, 51 were unexpected and included one homicide.

In the quarter, the web-based system supported over 2,300 users statewide. The database managed more than 2,665 reports with 1,201 monitored for follow-up.

Table #8. DY2 Q2 Critical Incidents

1. Critical Incident Types by Population Group						
	Centennial Care		Behavioral		Self Directed	
	#	%	#	%	#	%
Abuse	224	7%	57	28%	13	11%
Death	341		9		10	
Natural/Expected	290	9%	1	0%	8	7%
Unexpected	50	2%	8	4%	2	2%
Homicide	1	0%	0	0%	0	0%
Suicide	0	0%	0	0%	0	0%
Emergency Services	1600	51%	72	35%	67	56%
Environmental Hazard	36	1%	0	0%	1	1%
Exploitation	104	3%	1	0%	9	8%
Law Enforcement	116	4%	28	14%	5	4%
Medication/Treatment Error	6	0%	4	2%	0	0%
Missing/Elopment	57	2%	13	6%	1	1%
Neglect	302	10%	10	5%	3	3%
Total	3127		203		119	

Self-Directed Community Benefit

HSD collaborates with the MCOs regarding the self-directed community benefit (SDCB) on a scheduled and "as needed" basis. Following the Centennial Care Policy Manual revision effective March 3, 2015, HSD provided an informational training to the MCOs on May 4, 2015. The policy manual revisions for SDCB were presented and discussed. Since that training, the MCOs presented four member cases to HSD, for which technical assistance was needed regarding the grandfathered budget amounts and grandfathered rates, for individuals who transitioned from the Mi Via waiver to the Centennial Care SDCB on January 1, 2014. Conference calls were held and applicable corrections were made.

SDCB staff continues to participate in weekly or bi-weekly "high-utilizer" conference calls with each of the MCOs during which complex issues related to the SDCB services are discussed. The calls are used as educational opportunities for the MCOs, particularly care coordinators and support brokers. In addition, SDCB staff began work related to the transition of the medically fragile (MF) population, effective January 1, 2016.

Section VIII: American Indian/Alaska Native Reporting

The updated reporting tool for 2015 for the Native American Members Report added additional review criteria such as BH utilization, use of the ER for non-emergent conditions, dental utilization, pharmacy under and over utilization, and care coordination to name a few.

In DY2 Q2, two of the four MCOs showed a decrease in ER utilization for Native American enrollees for non-emergent conditions. There was no evidence of pharmacy under or over utilization. The majority of BH utilization was for treatment.

Access to Care
I/T/Us are concentrated near or on Tribal land where the majority of Native Americans live and receive services. Native Americans in Centennial Care may access services at 638 IHS and Tribal clinics at any time.

Contracting Between MCOs and I/T/U Providers
The MCOs continue to reach out to Indian Health Service (IHS), Tribal health providers, and Urban Indian providers (I/T/Us) to develop agreements even though they are not required to contract with the MCOs under Centennial Care.

For this reporting period, there are established MCO partnerships with Tribal communities for translation, transportation, BH services, optical services, audiology, home health, and medical supply services.

Ensuring Timely Payment for All I/T/U Providers
All four MCOs met timely payment requirements ranging from 93 percent to 99 percent of claims being processed and paid timely within 30 days of receipt.

Table #9. Issues Identified and Recommendations Made by the Native American Advisory Board (NAAB) and the Native American Technical Advisory Committee (NATAC)

MCO	Location/Date of Board Meeting	Issues/Recommendations
BCBSNM	Crownpoint, NM 06/10/15	BCBSNM held their second quarter NAAB meeting at the Crownpoint Chapter House. About 35 people were in attendance. Good audience participation and interaction. No concerns.
MHNM	Gallup, NM 05/08/15	MHNM had a very large turnout at this event (well over 60 people). MHNM answered questions on care coordination, MHNM providers in the Gallup area, prescriptions, and Centennial Rewards.
PHP	Gallup, NM 06/19/15	PHP presented on their traditional healing benefit and explained how care coordination works. About 15 people attended the meeting.
UHC	Farmington, NM 06/04/15	There were around 14 providers present for this NAAB meeting. There were guest speakers from the American Cancer Society, Logisticare (transportation vendor), and a Traditionalist from First Nations Community Healthsource.

The most recent NATAC meeting for this quarter was May 18, 2015. There was one new board member appointed by his Tribal leadership at the meeting. For the next meeting, the committee asked to see the number of Native Americans enrolled in institutional care/community based services, review the Native American report data that is provided quarterly by the MCOs and to continue the discussion on the MMIS and ICD-10.

Section IX: MCO Action Plans for Addressing Identified Issues

Please see Attachment D: MCO Action Plans Grid.

Section X: Financial/Budget Neutrality Development/Issues

HSD is currently in the process of finalizing a mid-year managed care rate adjustment for all programs within Centennial Care. These adjustments include a NF rate increase that was appropriated through legislation and expanding autism benefits to meet CMS requirements. These rate adjustments are not anticipated to affect budget neutrality. Once the mid-year rate adjustments are in place, HSD and its actuary will be working on DY3 rate developments for all programs to be effective January 1, 2016. New Mexico will closely monitor rate development for impacts to budget neutrality.

New Mexico continues to meet budget neutrality with the addition of DY2 Q2 data, assessing budget neutrality based on current demonstration year PMPMs. HSD is continuing to analyze MEG 5 as it continues to exceed its own budget neutrality limit for DY2 Q1 and Q2. HSD has pulled the specific claim data for this group as reported on the CMS-64 to look at this population and claim reporting in detail. See Attachment A: Budget Neutrality Spreadsheet April 1, 2015-June 30, 2015.

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 #10. DY2 Q2 Member Months

Eligibility Group	Member Month
Population 1 – TANF and Related	1,087,793
Population 2 – SSI and Related – Medicaid Only	124,056
Population 3 – SSI and Related – Dual	106,156
Population 4 – 217-like Group – Medicaid Only	602
Population 5 – 217-like Group – Dual	6,532
Population 6 – VIII Group (expansion)	666,030
Total	1,991,169

Section XII: Consumer Issues (Complaints and Grievances)

A total of 800 grievances were filed by all Centennial Care members in DY2 Q2. There was a decrease in member grievances from the previous quarter (956). Non-emergency ground transportation continues to constitute the largest number of grievances reported with 331 (41 percent) of total grievances. MCOs express continued commitment to work on reducing member dissatisfaction by providing feedback to their individual transportation vendors, reviewing vendor processes and implementing action plans as necessary.

Sixty-one (7.6 percent) of the total 800 grievances reported were with regard to PCPs. Fifty-eight (7.2 percent) of the total 800 grievances reported were related to other specialties. Specific member reported grievances include dissatisfaction with care provided, provider denied pain medication, disrespectful staff, and a variety of other issues that do not indicate any specific trends. Fifty-three (6.6 percent) of the total 800 grievances were related to dental services. These include dissatisfaction with partials and dentures not fitting properly and members receiving billing statements of balance due.

Section XIII: Quality Assurance/Monitoring Activity

Care Plans

The HSD/MAD Quality Bureau (QB) continues to randomly review care plans to ensure that the MCOs are using the correct tools and processes to create plans. The review of care plans also ensures that the MCOs are appropriately allocating time and implementing the services identified in the member's care needs assessment, and that the member's goals are identified in the care plan. In the June 2015 audit, HSD found a miscalculation in the allocation of PCS hours allocated to one member. The MCO recalculated the hours, resulting in an increase of PCS hours for the member. No other concerns where identified in the second quarter of 2015.

Table #11. DY2 Service Plan Audit

Service Plans	DY2 Q1	DY2 Q2
Number of member files audited	120	120
Percent of service plans with personalized goals matching identified needs	100%	100%
Percent of service plans with hours allocated matching needs	100%	99.2%

Nursing Facility Level of Care (NF LOC)

QB continues to review high NF LOC and community benefit NF LOC denials on a quarterly basis to ensure the denials were appropriate and based on NF LOC criteria. No concerns were identified in the second quarter of 2015.

Table #12. DY2 NFLOC Audit

High NF Denied Requests (Downgraded to Low NF)	DY2 Q1	DY2 Q2
Number of member files audited	14	15
Number of member files that met the appropriate level of care criteria	14	15
Percent of MCO level of care determination accuracy	100%	100%

Community Benefit Denied Requests	DY2 Q1	DY2 Q2
Number of member files audited	16	15
Number of member files that met the appropriate level of care criteria	16	15
Percent of MCO level of care determination accuracy	100%	100%

Care Coordination Monitoring Activities

HSD continues to monitor the MCOs' monthly progress based on their 2014 internal improvement plans from the December 2014 on-site care coordination audits. HSD is developing a plan to conduct another care coordination audit in the fall of 2015. The audit will assure the long-term progress and effectiveness of the MCOs' internal action plans and review and identify any gaps in care coordination timeliness, training initiatives and ongoing quality improvement efforts.

Section XIV: Managed Care Reporting Requirements

MCO Reporting Process
HSD modified its managed care report revision process during the quarter, establishing quality control standards and operating under a continuous quality improvement approach. This process has been deployed to internal and external stakeholders including the MCOs. Improvements to the reports will be ongoing in response to the continuous feedback loop from the stakeholders. Approved changes for report requirements will be integrated throughout the system.

Customer Service

Call Centers
All call center contract metrics (abandonment rate, speed of answer and wait time) for all customer services lines (member services, provider services, nurse advice line and the utilization management line) were met by each MCO during the quarter.

Appeals
A total of 1,305 appeals were filed by members of all MCOs in DY2 Q2. Of the total appeals filed, 623 (48 percent) were upheld, 236 (18 percent) were overturned and 446 (34 percent) are pending resolution. Pending appeals include those that have been carried over from prior quarters (due to the 30 day timeframe crossing over into the next quarter) and extensions. All MCOs have processed appeals in a timely manner.

All MCOs combined report that 1,104 (84.6 percent) appeals were due to denial or limited authorization of a requested service. One hundred and twenty-five (9.6 percent) appeals were due to reduction of a previously authorized service. All other reasons for appeals constitute less than five percent of the total. Trending identified that denials or limited authorization of requested services are the most common reasons for appeals across all four MCOs.

A total of 4,301 appeals were filed by providers in the second quarter. Of the total appeals filed, 3,734 (87 percent) were due to denial of partial or full payment for a service. MCOs identified which providers were having issues with claim submission and provided technical support to these billers. HSD anticipates that this will reduce the number of denied claims being submitted for appeal. HSD will monitor provider appeals for improvement.

Section XV: Demonstration Evaluation

Progress under the work plan continued as expected with DY2 Q2 activities generally devoted to data identification and acquisition. Since the start of the quarter, the evaluation contractor, Deloitte, has met with HSD weekly to further refine the work plan and data request.

Proposed Evaluation Work Plan
During the second quarter of 2015, the Deloitte team continued to work with HSD to identify the various data elements needed to conduct the evaluation. In addition, Deloitte began to develop the Evaluation Model that will incorporate both the pre-Centennial Care baseline (without-waiver) and the Centennial Care (with-waiver) measures. Deloitte also began outlining the structure of the Annual Report, including the format of the tables and exhibits to be included.

During the quarter, Deloitte received over 100 reports from HSD through HSD's secure data transfer system. The team reviewed each report to identify and acquire the appropriate data elements. As of the end of the quarter, Deloitte had received the data needed to complete the first year evaluation for one of the 125 measures under review (EPSDT Screening Ratio). Data collection efforts remain underway for the remaining 68 measures.

Baseline Measures
Work continues on establishing the baseline measures using pre-Centennial Care data where applicable. Deloitte will provide HSD all assumptions to review for appropriateness and reasonableness before they are incorporated into the baseline measures.

Annual Report
A template for the Annual Report is being developed. Deloitte will share this with HSD for its input and will revise as necessary. As required, the annual report will contain information on the progress made during the year, the key milestones achieved; challenges and delays experienced, and associated mitigation strategies. Interim findings will be included when available.

Section XVI: Enclosures/Attachments

Attachment A: Budget Neutrality Tables (April 1, 2015-June 30, 2015)

Attachment B: GeoAccess PH

Attachment C: GeoAccess BH

Attachment D: MCO Action Plans

Attachment E: 2014 Pharmacy Utilization

Section XVII: State Contacts

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Section XVIII: Additional Comments

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

Centennial Care Success Story #1
A Centennial Care member is a 47 year old female who suffered from alcohol abuse for over 15 years. The member had gone to the emergency room several times due to alcohol overdose. The community health worker (CHW) met with member at her home. The member told the CHW that she starts drinking sometimes because she has a lot of time on her hands. She would like to work and stay busy so she does not think about drinking. The CHW provided the member with employment and counseling resources. She told the CHW that she would contact the resources to schedule appointment. The CHW also found out by going to the home and completing a health assessment that the member had not had a mammogram and physical in quite some time. The CHW asked her if she would like assistance in making those appointments since the CHW was there at her home. The member told the CHW that would be very helpful and the CHW called the clinic and set up the member's appointments. Later, the CHW followed-up with the member and found out that she started working part time as a caregiver and was attending counseling classes once a week at her church. The member also told the CHW that she had attended her medical appointments and was thankful to the CHW for helping her with scheduling appointments and providing resources.

Centennial Care Success Story #2
A Centennial Care member is morbidly obese and requires knee surgery, which her doctors won't approve until she loses weight. Last fall, the member was home bound and had problems with falling and not being able to get up, was struggling with depression, and was not seeing her therapist. Her self-esteem was very low. The care coordinator worked with the member to help her receive bariatric surgery. The process has been a difficult journey for the member and there have been many times when she has wanted to give up and has been discouraged.

Care coordination has assisted the member in helping her navigate discouraging events and working with providers. The care coordinator talked with the member and her therapist and assisted the member in resolving issues with some of her providers. Presently, the member is scheduled to receive bariatric surgery. She is seeing her therapist regularly, going to the pool three times per week, has lost 27 pounds on her own and reports that many of her depressive symptoms have gone away. The care coordinator feels that the process of getting ready for the surgery has been life changing for the member. Her ultimate goal is to go back to work, have knee surgery and be independent again.

Centennial Care Success Story #3
A care coordinator assisted an elderly Spanish-speaking member who was on many medications for several diagnoses, including diabetes. Despite all of the medications, the member often felt ill and had difficulty breathing. The care coordinator spent quite a bit of time with the member, discussing his diagnoses, teaching him the importance of complying with his doctor's orders and emphasizing that he takes his medications as prescribed. The member did not want to see his physician again because he felt that the doctor was not helping him. There was also a language barrier as the physician did not speak Spanish. The care coordinator assisted the member with finding a new Spanish-speaking physician and suggested that he request bloodwork be done. His new physician discovered that the member was not diabetic, and several of the medications were discontinued. Now, the member is regularly seeing his new physician and is active, walking a mile each day. He told the care coordinator that he is happy and grateful for her assistance.

Centennial Care Success Story #4
A Centennial Care member was diagnosed with a rare form of cancer when she was twelve. The cancer was in the bone of one of her legs. Surgery was performed to replace her hip joint, and a metal rod was inserted to connect the upper and lower parts of her leg. The member is now a young adult, and several years ago, she started experiencing severe pain in her leg. It was determined the rod would need to be replaced. The care coordinator began working with her to schedule the needed surgery. Several surgeons evaluated the member and told her that it would be easier to have her leg amputated since the surgery was complicated. The member developed great anxiety at the thought of losing her leg. The care coordinator was able to find a specialist in California and worked to arrange transportation for the member to travel to see the surgeon for an evaluation. This specialist determined that the leg did not need to be amputated, and the member is scheduled to have surgery in a few weeks. She is hopeful again for the future and of finally living without the pain she has had to endure over the last few years.