Centennial Care Waiver Demonstration

Section 1115 Quarterly Report
Demonstration Year: 1 (1/1/2014 – 12/31/2014)
Federal Fiscal Quarter: 3/2014

11/26/14

New Mexico Human Services Department

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 18 percent of the State's total General Fund budget each year. In State Fiscal Year (SFY) 2012, New Mexico and the federal government spent approximately four billion dollars on Medicaid services for New Mexicans. With the Governor's decision to expand Medicaid to newly eligibles beginning in January 2014, the State projected an addition of approximately 170,000 new enrollees to the program by June 2015. All of these factors, combined with rising program costs, necessitated modernization of the Medicaid program.

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

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

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

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

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

Key Dates

In August 2012, HSD submitted its Section 1115 demonstration waiver proposal to the Centers for Medicare & Medicaid Services (CMS) and released its competitive procurement to secure the MCOs that would administer the new integrated program. HSD received proposal submissions

from bidders in November 2012 and awarded contracts to four MCOs in February 2013. In order to conduct a comprehensive readiness review process, the contracts were awarded almost a full year in advance of Centennial Care's commencement on January 1, 2014. The Centennial Care MCOs are:

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

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

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

As noted in Section III of this report, there are 182,996 new enrollees in the Group VIII/expansion who are in Centennial Care. This is an increase of 22,975 enrollees from the prior quarter.

Enrollment

Overall enrollment for Centennial Care has increased since January. Although there have been fluctuations in some populations, the Group VIII/expansion population continues to increase each quarter, thus contributing 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) as the next largest group as reflected in Section III of this report.

Disenrollment

HSD continues to implement the short-term fix for the isolated disenrollment for Centennial Care members that was identified and addressed in the second quarter. The isolated disenrollment was linked to the processing of the eligibility file between the Automated System Program and Eligibility Network (ASPEN) that determines eligibility and the Medicaid Management Information System (MMIS) that determines enrollment and disenrollment to Centennial Care. The long-term fix to resolve these disenrollment issues will be implemented in the fourth quarter. The long-term fix will send all eligibility spans from the earliest certified eligibility month for all categories of eligibility going forward. This will ensure that ASPEN is sending all eligibility to the MMIS to avoid eligibility gaps and issues that result in disenrollment.

Access

Throughout this report, unless otherwise indicated, the most current monthly data is through August 2014. Quarterly data is available through the second quarter.

Primary Care Providers (PCP)

The Primary Care Provider (PCP)-to-member ratio standard of 1:1500 was met by all MCOs in urban, rural and frontier counties in August 2014. The percentage of open panels ranged from 83.1 percent to 97 percent. There are no identifiable PCP concerns at this time.

Physical Health (PH)

Geographic access standards were met by all MCOs for general hospitals and pharmacies in urban, rural and frontier counties in the second quarter (see Attachment B). Specialty areas that met access standards across MCOs and across urban, rural and frontier areas include: cardiology, dental, ear, nose and throat (ENT), obstetrics and gynecology (OB/GYN), orthopedics, pediatrics and podiatry. In addition, BCBSNM improved access in frontier counties, as compared to quarter

one, by meeting the standard for neurology. MHNM improved access in urban counties by meeting the standards for dermatology, endocrinology, hematology/oncology and neurosurgery.

With the exception of MHNM, MCOs did not meet access standards for dermatology. MHNM met access standards for dermatology in urban and frontier areas. With the exception of urology, access deficiencies were found primarily in the rural and frontier areas. Urology standards were met by all MCOs in urban areas. Specialties, for which standards were not met in rural and frontier areas, include: endocrinology, hematology/oncology, neurology and rheumatology.

MCOs were able to increase the number of providers for some specialties where access standards had not been met in either prior quarter. BCBSNM reported improvement in rural counties for: dermatology, endocrinology, hematology/oncology and neurosurgery. MHNM reported improvement in urban counties for dermatology, rural counties for dermatology, endocrinology, neurosurgery and rheumatology, and in frontier counties for neurosurgery. PHP improved access in rural and frontier counties for dermatology and endocrinology.

There were also improvements in the second quarter for access standards which had been met in the first quarter. BCBSNM increased cardiology services to include all 14 rural counties. Access to PCPs increased from 14 to 15 frontier counties. BCBSNM also reported that it added seven hospitals statewide and has now contracted with Federally Qualified Health Centers (FQHCs) in all 33 counties. In urban areas, MHNM enrolled new providers in cardiology, ENT, neurology, orthopedics and podiatry. MHNM also improved access to ENT and neurology services in rural counties, and access to ENT, OB/GYN and pediatrics was improved in frontier counties.

To further strengthen its network, BCBSNM uses Strennus Network360® Market Analysis Report to identify available PH and LTC providers in New Mexico and border areas and compare the BCBSNM network of contracted providers to all available providers.

MHNM's provider services and quality improvement staff added resources to its operations to focus on retention and provider satisfaction by providing support, training, and technical assistance to existing and new providers. MHNM also reported that it continues to collaborate with the University of New Mexico's Project ECHO to facilitate consultation and effective knowledge transfer; provide education regarding access standards; and promote their 24-hour nurse advice line.

MCOs are continuing their recruitment and contracting efforts. Further, through single-case agreements, each MCO arranges for members to receive medically necessary care from non-participating providers if the members' needs cannot be met within the MCO's network. Members are also assisted with transportation to ensure timely access to care.

Long-Term Care

In the second quarter, all MCOs met access standards for both delegated and directed personal care service agencies in urban counties. Standards for assisted living facilities (ALFs) in rural counties were not met by any of the MCOs. In addition, PHP did not meet the standard in urban counties. BCBSNM and MHNM did not meet standards in frontier counties, and MHNM did not meet standards in urban or rural counties for nursing facilities.

During the fourth quarter, HSD will compare the list of Medicaid approved ALF providers with those contracted by the MCOs. While most ALFs are located in urban areas, it is important that the MCOs contract with as many providers as are available in the rural and frontier areas. There were very few access-related member grievances in July (15) and August (four), and there were none regarding access to ALFs.

While MHNM did not meet the access standard for nursing facilities (NFs) in both urban and rural areas, MHNM has contracted with all providers in those areas. MHNM has the highest number of enrolled members, and this affects the provider-to-member ratios. It is important to note that although all members are included when analyzing geographic standards, not all members will require ALF or nursing facility (NF) services. MHNM reviews network gaps and when deficiencies are identified, interventions and target timeframes are set depending on the nature and urgency of the identified gap.

Transportation

New Mexico has a very low population density as well as health professional shortage areas, in whole or in part, in all of its 33 counties.[1] As such, non-emergency transportation is essential to facilitate access to care. After discovering an error in its GeoAccess reporting, BCBSNM provided updated report data and subsequently met standards for transportation in every geographic area. MHNM and PHP also met access standards for each geographic area. UHC met standards in urban and rural areas but did not meet the standard for frontier areas.

UHC subcontracts transportation with Logisticare. This subcontractor has had numerous member complaints and grievances. UHC reported that from January through July, there were 75 "appointment standard availability/timeliness" member grievances, 50 "transportation not available" grievances, 36 "dissatisfaction with provider" grievances, and 10 "health, safety and/or exploitation" grievances. A multi-faceted action plan was developed which includes, but is not limited to the following: expanding the fleet; completing daily operational reviews; reviewing weekly trip trends; conducting weekly service reviews; and, following up with complaints. Actions began in September 2014 and are ongoing. See Section XII for more information related to grievances.

Logisticare is working closely with the MCOs to identify and recruit additional providers in the rural and frontier counties. Logisticare will also work with I/T/U providers to support Native American members' transportation needs.

Telemedicine

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

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

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

HSD has joined with the University of New Mexico to expand access to clinical supervision for BH providers. This includes exploring the use of telemedicine technology where access is limited in rural areas or where appropriately licensed clinicians are not available. This has been shown to include its own set of barriers relative to regulations, licensure requirements, and national standards for clinical supervision both with respect to social workers and counselors. The restrictions are being investigated and are a point of discussion with licensing boards to address changes to regulations. HSD will continue to identify how to make appropriate changes to expand existing boundaries of practice while not compromising quality of supervision delivery.

In this quarter, HSD held a state-wide training for providers through the American Group Psychotherapy Association (AGPA). A train-the-trainer model was used and led to the certification of over 25 participants who can now train other practitioners. The 25 participants will expand this modality and potentially increase service capacity.

Service Delivery

Behavioral Health Services

Concerns about wait times for BH services prompted HSD to closely monitor this area in the third quarter. MHNM hired a consulting firm to study wait times and will have evidence to report to HSD in November. UHC and PHP reported to HSD on wait times. HSD continues to monitor and address this issue with each MCO in regularly monthly meetings.

UHC queried 26 care coordinators from three regions of the state. UHC noted that this was just a sample and the data was anecdotal. However, it did provide insight into wait times. Lack of access, particularly in the northern part of the state was an issue. UHC will explore telehealth as a possible solution. HSD is reviewing multiple actions to increase available BH workforce.

PHP used a different methodology. Six high volume CSAs were contacted via phone and/or surveyed by email to obtain the data to complete a survey on wait times. The providers represented three geographical regions (Southeast, Central, and Southwest) and one statewide.

PHP noted reasons other than access that contribute to wait times:

- Lack of providers
- Member attendance
- Increased member access
- Lack of bilingual providers
- Members' phone numbers change
- Lack of transportation for members

The results of the findings were shared with the CSA MCO team. HSD will continue to work toward building access throughout the state and bring the findings to both the Behavioral Health Provider Association and the Administrative Burden Reduction workgroup.

Autism Services

The expansion of the array of autism services prompted the formation of the Autism Care Coordination Council (AC3). Previously, an autism oversight committee existed. The committee worked on difficult cases and wrote reports for the legislature.

In 2014, applied behavioral analysis (ABA) (NMAC 8.321.2.10) became a part of the specialized BH services. The rule requires the expansion of services to Medicaid recipients under 21 years of age and includes three stages of services. The three-stage comprehensive approach to assessment and treatment stipulates that ABA be provided in conjunction with other medically necessary services (e.g., occupational therapy, speech language therapy, medication management, etc.). The three stages include assessment, creation of a behavioral analytic plan, and implementation of the plan. This service necessitates an increased workforce to assess, plan and provide the service. Further, access to ABA services also requires the expansion of qualified providers in the state. Currently, at the University of New Mexico, there is an ABA certification program housed in the special education department.

Knowing this service would require cooperative efforts between the MCOs and the state, the AC3 was formed. Participants from the four MCOs include BH staff and autism specialists.

Included in the AC3 work is developing training for care coordinators who are often the first point of contact for the MCO. Care coordinators need to be prepared to guide families through the new array of services.

Comprehensive Community Support Services

HSD has been engaging both providers and MCOs in a dialogue about expansion of Comprehensive Community Support Services (CCSS) services and workforce capacity. Through the dialog, barriers have been identified and a course of action set. Barriers appear to be larger system issues that cannot necessarily be attributed to one facet of service delivery. Some of the identified barriers include licensure board requirements, reciprocity, access to clinical supervision, antiquated regulations or service definitions, retention of skilled and independently licensed practitioners, credentialing, training, system changes, and collaboration between entities that have oversight in those respective realms.

Several of the strategies put in motion by the MCOs and HSD include scheduling meetings with licensing boards and other constituents and also include: consulting with local and state universities; creating a visual through cross walking licensure and regulation requirement; a charge to existing workgroups to investigate the identified barriers and proposing solutions; and continuing to engage providers through ongoing communication both in face-to-face meetings and email. For example, the Social Work Board has already recognized some of the workforce challenges, including reciprocity and supervision, and is working on appropriate adjustments to regulations and guidelines. The Counseling and Therapy Practice Board is taking similar steps to address quality supervision in the state through legislative proposals.

Pharmacy

In August, a revised, monthly Pharmacy Report was implemented and now includes BH pharmacy utilization. Prior authorization requests and denials for medications will be reported to HSD, and the MCOs will provide analysis and explanations for any high denial rates.

New Mexico's rate of accidental and preventable deaths associated with licit and illicit opioids has historically been one of the highest in the country. In the last two years (2011 through 2013), however, the rate was significantly reduced by16 percent.[2] Building on these successes, HSD issued Letter of Direction (LOD) #27 regarding opioid prescription monitoring to Centennial Care MCOs. An Oversight Task Force was convened in July with representation from each of the four MCOs. A monitoring program was developed using retrospective claims history review. Providers were notified of the new program and uniform monitoring was implemented throughout the system.

In addition to the opioid prescription monitoring program, a single process was developed and implemented by all MCOs to continue monitoring Suboxone® utilization. A single authorization request form was instituted, and communications to providers and patients were drafted. Edits were built into the Rx claims processing system to allow the induction phase of treatment without a prior authorization and to deny any opioid medication utilization once a member begins treatment with Suboxone®.

Also in the third quarter, the MCOs worked together on a Hepatitis C treatment initiative. The MCOs created a common treatment request checklist that standardizes the process for all MCOs and streamlines the prior authorization review process. The checklist was carefully reviewed by HSD and a network of medical experts. The checklist was modified 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. HSD directed the MCOs to revise their treatment guidelines based on HSD's modifications to the checklist.

HSD requested involvement in the MCOs' Pharmacy and Therapeutics (P and T) committees to confirm that MCOs are evaluating and adopting new pharmaceuticals based on clinical and economic value. HSD has concerns with formulary deletions and prior authorization requirements for some medications. For example, HSD issued LOD #28 to have MCOs cover Human Immunodeficiency Virus (HIV) drugs without requiring prior authorization. Further, as new HIV drugs become available, HSD directed that the MCOs must not subject them to formulary restrictions, but automatically approve and add these drugs to their formularies. To date, one MCO, PHP, has agreed to allow HSD to participate in its P and T committee meetings.

Nursing Facilities

All four MCOs have implemented internal action plans for nursing facility level of care (NF LOC) determination turnaround times (TATs). The TAT standard for NF LOCs is five business days. In the third quarter, HSD received data from each MCO in order to evaluate the effectiveness of the internal action plans.

BCBSNM reported a 97 percent compliance rate for NF LOC determination TATs. BCBSNM also reported having initiated an action plan to test a fax process, which had been identified as a barrier, and the process was remediated.

PHP reported a 91 percent TAT compliance rate in the third quarter, and a 97 percent rate of compliance since initiating its action plan. PHP attributes its improvement to increasing staff, providing additional training, and adding measures to more closely monitor where each case is in the process. PHP continued its action plan in order to reach full compliance. It was determined that in the 3 percent of cases, which had exceed the five day TAT, case complexity had warranted medical director review. That review process was streamlined, closely monitored, and additional medical director resources added to support the work load. As of September, PHP reported a 100 percent compliance rate.

MHNM had an average 83 percent compliance rate for the quarter. In addition to a "setting of care" systems issue (see Section VI), MHNM indicated that one facility in particular had not responded to requests for additional information to support high nursing facility level of care (HNF) requests. MHNM's utilization management (UM) team contacted the institutional care coordinator who, in turn, contacted the facility in question. Facility staff was provided with

education regarding required documentation for HNF requests. MHNM's compliance rate is expected to improve in the fourth quarter as a result of these efforts.

In the third quarter, UHC had 24 percent more NF LOC determinations to process than all three of the other MCOs combined (a total of 1,259 members). In addition to the same systems issue referenced above, UHC did not appear to be adequately prepared to complete this volume of determinations within specified timeframes and initiated an action plan early in the quarter to address a backlog. By the close of the quarter, UHC reported that NF LOC determinations were current and that UHC was meeting the five business day TAT. UHC further reported that various provider concerns were addressed during the backlog which resulted in no disruptions to care or services for members.

In August, HSD facilitated one-on-one trainings for processing crossover claims. HSD has not received any further complaints from providers regarding crossover claim payments. There were no appeals regarding NF LOC determinations in July or August. September report data is pending final review and will be reported in the next quarterly submission.

Emergency Rooms

In an effort to address unnecessary use of emergency room (ER) services, MHNM developed and widely distributed a PCP ER Diversion Tool Kit during the reporting period.

In 2010, PHP developed and implemented its Emergency Department Patient Navigation Project. This project continues as part of Centennial Care. Please see Attachment E for more information about this program.

Durable Medical Equipment

In September, PHP expanded its provider network to include an additional DME provider-HME specialist. PHP's Centennial Care members now have access to both HME specialists and Apria Healthcare, Inc. for their DME needs. This expansion helped to fulfill the shortage of equipment previously being experienced by providers and members. For example, HME specialists guaranteed a number of bilirubin blankets be set aside specifically for Centennial Care members and has them readily available for all babies who have been deemed in need of this service upon discharge from the hospital.

School-Based Health Centers

The MCOs collaborated with HSD and the Office of School and Adolescent Health to create a universal School-Based Health Centers (SBHCs) site review tool. The new tool creates a convenient and efficient system for SBHCs to receive necessary certification from the MCOs.

Provider Network

In addition to the GeoAccess Report, HSD monitors provider-to-member ratios as well as new providers, suspended or terminated providers, and the number of single case agreements initiated each

quarter. PHP reported a significant increase in the number of BH providers for the second quarter (from 470 to 3,676). MHNM performed a routine systems audit for its provider database, and MHNM removed duplicate providers and made corrections to some provider specialties which had been incorrectly loaded into the system. These processes resulted in some significant adjustments for the second quarter (from 9,863 to 6,627 PH providers and 3,085 to 2,504 BH providers). Nevertheless, MHNM, as well as the other MCOs, continued to meet contractually required provider-to-member ratios.

Provider terminations in the second quarter were primarily due to normal attrition such as providers leaving the state or discontinuing practice. One provider was suspended this quarter. MHNM updated its system within 24 hours and relayed the information to all delegated vendors, as required. The physician was sanctioned and is on the Office of Inspector General (OIG) list. There were no trends for single case agreements during the reporting period. Each MCO remains active in recruiting and retaining providers.

Member Rewards

Following full implementation of the Centennial Rewards program during the second quarter, activity in the past three months has focused on increased engagement. The success of an incentive program like Centennial Rewards will hinge on this engagement of the beneficiaries. While the Centennial Rewards program is designed to allow members to earn points even when unaware of the program, the end result should be that a significant portion of the Medicaid population will eventually be participating in their own health care. Large numbers of members have gotten involved in the first year – whether they know that or not – and will be more likely to fully buy into Centennial Care goals and their own health outcomes as they learn more about the program in year two and beyond.

Through September 30, 2014, approximately 200,000 Centennial Care members had earned points through the Rewards program. Total dollar value earned was over $7 million. However, as of that date only about $300,000 in points had been redeemed for rewards, and only 17,000 members were registered in the system as program participants.

To improve program awareness and engagement, the MCOs have been actively involved in outreach, communication, and marketing. Currently, program information is included in MCO member materials and welcome packets. It is also mailed directly to members. The call center is using outbound calls during non-peak hours to reach out to members who have accrued points but have not yet registered for reward redemption. The state is also working on a provider engagement program, as evidence suggests that the involvement of health care professionals is another positive factor in changing beneficiary behavior. A provider-specific portal is planned for later this year. Finally, a public website is now operational, allowing anyone to learn about the program without needing to register (www.centennialrewards.com).

A signal that these efforts are working is that the number of registered members has doubled during the third quarter and was over 17,000 by the end of September. The number continues to rise significantly each week, as does the percent of points redeemed. The redemption rate was less than one percent at the end of June and by the end of September was around three percent.

Another notable achievement for the third quarter was the full implementation of the Centennial Rewards debit card. Members are now able to redeem points for the card as well as items from the catalog and they can use the card just like cash at several retail outlets around New Mexico.

Community Interveners

All four MCOs have contracted with Community Outreach Program for the Deaf (COPD) for Community Intervener (CI) services. HSD directed the MCOs to contract with other providers of CI services as they become available.

COPD reported that consumers began receiving Community Intervener services under Centennial Care in August 2014. There are currently seven Centennial Care members receiving Community Intervener services. COPD reported a total of 159 hours of services provided during the quarter. Claims and utilization data will be available in the fourth quarter.

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 1. Enrollment Activity

Demonstration Population	Total Number of Demonstration Participants Quarter Ending – Sept 2014	Current Enrollees (Year to Date)*	Disenrolled in Current Quarter**
Population 1 – TANF and Related	376,747	378,143	22,762
Population 2 – SSI and Related – Medicaid Only	39,118	39,270	1,625
Population 3 – SSI and Related – Dual	33,240	35,373	1,172
Population 4 – 217-like Group – Medicaid Only	2,362	2,431	64
Population 5 – 217-like Group – Dual	4,693	5,056	119
Population 6 – VIII Group (expansion)	182,996	205,385	12,258
Totals	634,156	665,658	38,000

*Since members change eligibility and thus MEGs during the year, the only way to give an unduplicated count for YTD is to look at the last month a member was in the MEG within the period.

** “Disenrolled” is defined as those enrolled during the previous reporting quarter who did not have enrollment at the beginning of the subsequent quarter. "Disenrolled" reflects a member’s shift from one MEG to another as well as those whose eligibility was terminated.

Section IV: Outreach

Through the Children's Health Insurance Program Reauthorization Act (CHIPRA) Cycle III grant award received by HSD, the Medical Assistance Division (MAD) developed an on-line screening tool and electronic application submission tool exclusively for the use of presumptive eligibility determiners (PEDs). This system, Yes New Mexico for PEDs (YESNM-PE), is available to PEDs state-wide. It accurately screens individuals (or entire households) for possible Medicaid eligibility. Once the screening is complete, PE is granted to eligible individuals. The system then allows the information supplied for the screening to be used in an application for ongoing eligibility if the individual chooses to apply for ongoing coverage.

To become an active PED, individuals must work for a "qualified entity." This includes individuals employed by hospitals, clinics, FQHCs, Indian Health Services (IHS) hospitals and clinics, community organizations and prisons or correctional facilities. Individuals at these facilities must complete a training course, complete a comprehension test, and sign a PED agreement that outlines responsibilities, HIPAA guidelines and client confidentiality. By the end of 2014, all PEDs will be required to screen clients for eligibility and submit ongoing applications via YESNM-PE unless system errors or internet connectivity issues do not allow YESNM-PE to be utilized.

YESNM-PE went "live" on May 8, 2014. Demonstrations on the use of the system have occurred via webinars on the first and third Friday of each month since that time. PEDs may attend these sessions but are not required to do so. Since going live in May, we have seen an increase in usage of YESNM-PE by PEDs and in the number of applications submitted.

Table 2. YESNM-PE

YESNM-PE Statistics	**Q2 May 8-June 30**	**Q3 July 1-Sept 30**
Total # of PEDs Who Utilized YESNM-PE	138	207
Total PE Applications Received	943	2423
Total # of Individuals Who Applied for Ongoing Medicaid Benefits	1531	1844
Individuals Approved for Ongoing Coverage	1181	1384
Individuals Denied	242	203
Individuals Pending	108	257
Total # of PEs Granted*	283	507

*All but two of the individuals who were granted PE between May and September applied for ongoing coverage.

Applications submitted via YESNM-PE are being processed very quickly. In most cases, they are processed within 24-48 hours. PEDs have said that utilizing YESNM-PE is much easier to accurately screen for eligibility than the former paper-based process. Also, the submission of the application for ongoing eligibility takes far less time. This enables PEDs to assist more people than ever before. When screening one household member for PE, they are able to screen all household members for potential Medicaid eligibility at the same time. The recipient's MCO choice (or opt-out choice for Native Americans) can be entered at the time of the PE screening/granting so that recipients have immediate access to care.

During the quarter, the MCOs continued aggressive outreach efforts, especially in Tribal areas. The HSD Native American Liaison attended more than 10 of these presentations and health fairs that included all four MCOs conducting Centennial Care outreach. Often these events bring 100-200 attendees. Each MCO has several Tribal Liaisons assigned to conduct outreach and education in various regions throughout the state.

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 have worked to submit daily and/or weekly production files to bring their encounters current. HSD continues to work with the MCOs to identify any gaps in provider enrollment that may be impacting encounter submissions. Since crossover claims continue to be a challenge, HSD provides guidance to the MCOs and facilitates any pending crossover encounters submissions.

In the third quarter, reporting tools to track the timeliness and accuracy of Centennial Care encounters were developed to ensure that encounters are monitored on a regular basis in accordance with each MCO's contract with HSD. HSD has developed a report for the MCOs to submit that shows the claims detail around timeliness and accuracy. This will allow HSD to compare what the MCO indicates they have submitted and what HSD identifies as being submitted to track and ensure completeness of encounters.

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

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

Program Development

Auto-Assigned PCPs and Member Change Requests

As of the August, UHC continued to report that 100 percent of new members are auto-assigned to a PCP. HSD has directed UHC to delay PCP auto-assignment until the sixteenth day from the eligibility load date for new members. HSD also directed UHC to exclude Native American members from the PCP auto-assignment process. UHC reported in its action plan that implementation for a systems-driven solution will be implemented on October 18, 2014 (see Section IX and Attachment D).

BCBSNM completed its internal action plan on October 1, 2014, to allow members 15 days before auto-assigning to a PCP on the sixteenth day (see Section IX and Attachment D).

In August, PHP reported approving 58.7 percent of PCP change requests. This percentage is significantly lower than the other MCOs; however, the number of denials may be due to PHP's members requesting providers who are not in-network. HSD will request that PHP expand its analysis if the relatively lower percentage becomes a trend.

Care Coordination and Contract Compliance

The MCOs continue to report challenges in locating and engaging their members in order to complete Health Risk Assessments (HRAs) and Comprehensive Needs Assessments (CNAs), which prevents or delays care coordination functions and activities for members.

On July 23, 2014, the MCOs reported not being able to reach approximately 40 percent of the overall membership. HSD directed all four MCOs to initiate unique and innovative campaigns to connect with their unreachable members. Each health plan was required to provide details as to how it would achieve a minimum decrease of 10 percent by October 1, 2014, and a five percent reduction in unreachable members each month thereafter. The MCOs were all successful in reaching the October goal and are expected to continue their efforts to reach their subsequent monthly goal using updated baseline data. As of October 2014, the MCOs succeeded in reducing the overall unreachable member population by 20 percent.

Table 3. Unreachable Members Campaign

Baseline as of July 17, 2014			**Update as of October 1, 2014**	
MCO	**Baseline**	**10 percent Target**	**Members Reached**	**Percent Improved**
BCBSNM	8,833	883	4,233	47.92%
MHNM	44,323	4,432	11,762	26.54%
PHP	137,938	13,794	24,981	18.11%
UHC	23,159	2,316	2,602	11.24%

Source: UTC Campaign (data as of October 3, 2014)

HSD also provides oversight of MCO care coordination activities to ensure that appropriate care coordination services are delivered to members. As such, HSD conducted a care coordination desk audit from July 14 through July 28, 2014. The purpose of the audit was to proactively identify and address any areas of concern during the first six months of implementation. While HSD's findings resulted in identifying several areas for improvement, it also provided an opportunity for the MCOs to make adjustments and corrections early in the demonstration.

This early audit facilitated an opportunity for collaboration with the MCOs to develop best practices in targeted areas, including case file documentation, so that each is able to achieve increased quality in its delivery of care coordination services. HSD made recommendations for additional, targeted staff training that will occur in October 2014. Full implementation of the best practice training is expected by November 1, 2014. HSD will revisit the MCOs during the week of December 15, 2014, to perform an onsite audit of each MCO with the expectation of improved case file documentation. The onsite audit will conclude December 18, 2014 and findings will be reported in the fourth quarter.

In addition to the audits, HSD monitoring and technical assistance activities included:

- Weekly technical assistance calls with the MCOs;
- Weekly contract manager calls with MCO leadership;
- Scheduled bi-weekly calls with contract managers, HSD leadership and MCO leadership;
- weekly contract manager calls with MCO leadership and care coordinators to discuss high-utilizer members who require more concentrated care coordination; and
- Bi-weekly meetings between MAD and BH Services Division (BHSD) contract managers to ensure communication and unified efforts.

HSD's Care Coordination Unit provides on-going education and training to internal and external parties regarding the importance of care coordination, and its relevance to members' successful participation in Centennial Care. HSD continues to track compliance with care coordination staffing ratios.

Due to a limited candidate pool for care coordination staff, the efforts to recruit and retain staff have been challenging for the MCOs. Three of the four MCOs have made progress, but continue to struggle with meeting the care coordination staffing ratio requirements. The fourth MCO, BCBSNM, did not meet staffing ratios throughout the quarter, primarily for Level 1. HSD continues to hold weekly meetings with MCOs to address care coordination staffing deficiencies. HSD is in discussion with the MCOs to reevaluate the staffing ratio requirement for Level 1 care coordination.

Core Service Agency Roster Data

HSD is focusing on the Centennial Care members who are receiving BH services through Core Service Agencies (CSAs) to ensure they are receiving appropriate care coordination from the

MCOs. In the quarter, the 16 CSAs submitted rosters of the Centennial Care members they serve to HSD. HSD then sent the rosters to each MCO to gather information on completion of HRAs and CNAs, care coordination levels, and unreachable members.

The collection of data revealed that 22,032 Centennial Care members receive services at the CSAs. These members have complex BH needs, their illnesses being the most severe. MHNM serves 7,196 members, PHP serves 6,746 members, UHC serves 4,279 members, and BCBSNM serves 3,811 members. CSA members account for three percent of the total Centennial Care membership.

HSD has identified that members receiving services at a CSA are less likely to have completed a HRA. During the next quarter, HSD will convene working meetings to further discuss how the MCOs and CSAs may employ new strategies to complete HRAs and CNAs for CSA members. HSD is meeting with each MCO to identify how it may support the MCOs to decrease the number of members without completed HRAs.

Electronic Visit Verification

The MCOs and First Data are working through implementation phases of the Electronic Visit Verification (EVV) system pilot project. EVV was scheduled to "go live" on October 1, 2014; however, full implementation was postponed until early next year. Instead, a phase-in approach has been implemented with several providers participating in a test phase. The MCOs, First Data, and the selected pilot providers are working toward full implementation by assessing concerns and issues as they arise during the test phase. HSD is closely monitoring progress and attends three weekly conference calls. Representatives from all four MCOs and First Data are in attendance during these calls as well as pilot providers.

HSD provides technical assistance and guidance regarding billing, authorizations, and other challenges posed by the pilot providers in relation to implementing the system across all lines of Medicaid LTC services. The MCOs have recently named a project lead that will meet with all parties and report progress weekly to HSD management. A governance committee was recently established as a decision-making body and includes: MCO, First Data, and HSD representation. This committee meets weekly. HSD will evaluate the progress and milestones reached by December 31, 2014, and will make recommendations for a "go live" date for all Centennial Care LTC providers.

BH Claims

During Quarter 3, provider concerns related to BH claims and denials increased. In response, HSD coordinated a day of face-to-face meetings to resolve billing and claims issues. CSAs were asked to submit specific billing denials or questions for each MCO. At the time of the face-to-face meeting, all parties were prepared to address the questions. Additional meetings will be offered to all BH providers as necessary.

To continue work on resolving similar problems, the MCOs with assistance from HSD developed a training to address the most frequent claims and billing issues. This training will be held in four locations throughout the state and will offer on-site and remote access to the training. The training is designed to meet the needs of the providers in rural, frontier, and urban areas.

Administrative Burden Reduction Workgroup

The Administrative Burden Reduction (ABR) workgroup has incorporated into its charge a review of credentialing protocols with MCOs in order to streamline processes and expedite timelines to ensure that there is one form where possible as opposed to several versions. This work is nearly complete with the end product anticipated. There will be a consolidated form, consistent timelines for application processing of 45 days, and a white paper with specific contact information for providers that will be made available on the HSD website. Lastly, the MCOs are completing a review of their provider manuals to ensure that there is uniform language defining credentialing and that the process is clearly outlined.

The ABR is also looking at areas related to the transition from DSM-IV-TR (ICD-9) to the DSM-5 (ICD-10), continued training for providers on billing and claims processing, and assessment guidelines review including that of the potential shift in the use of the DSM-IV-TR GAF tool as a determinant of qualification for some services.

BH Provider Training

Two groups are working to ensure that BH services in New Mexico are trauma informed and that recovery oriented systems of care principles are incorporated into any changes made according to SAMHSA guidelines; the Recovery Oriented System of Care State-Wide Committee (ROSC) and the Trauma Informed Care Advisory Committee (TIC). The ROSC meets on a monthly basis and has set a goal of acquiring a mobile unit to better meet the needs across the state in areas that do not traditionally have access or seek access to BH services. The reasons are varied and can include everything from a lack of transportation to stigma around seeking out those services. The TIC has a goal to ensure that all scopes of work include language that creates accountability for service delivery that is not only informed in trauma care, and recovery follow- up, but also utilizes approved evidence based practices. These include agency self-assessment pieces that can help facilities self-evaluate. The ROSC is also comprised of a sub-workgroup called the "treatment team". They are focused on reducing recidivism in the state and engage our criminal justice system in a conversation of appropriate consideration and intervention for those with mental illness and substance use disorder. There are regular meetings in the form of "brown bag lunches" with judges and attorneys to explore how to bridge gaps in access. This includes joining forces with other initiatives including crisis intervention teams and presumptive eligibility determination processes.

Health Plan Contract Compliance and Financial Performance Relevant to the Demonstration

HSD actively monitors the MCOs to track and address member and provider issues and ensure contract standards are met. HSD also requires detailed financial reporting to monitor expenditures for various services across programs (PH, BH, and LTC). Programmatic monitoring is done primarily by the Centennial Care Bureau while financial monitoring is mostly the responsibility of the Financial Management Bureau. Across all reports – program and financial – HSD provides feedback to the MCOs and requires additional information or re-submission of reports if there are significant issues.

HSD received the first set of comprehensive MCO financial reports on August 15, 2014. These reports covered the period from January 1 to June 30, 2014. As this was the first submission for most of these reports, HSD found it necessary to work closely with all of the MCOs to clarify issues and anomalies and put processes in place for future report submissions. The analysis of this first round of reports was focused on completeness and accuracy and many of the reports needed to be re-submitted due to errors of construction. That is, the MCOs often had difficulty using the new report templates and needed additional guidance.

HSD is more confident that the reports submitted on November 15 will yield more accurate data that can lead to a more substantive analysis of the expenditures under the Centennial Care program, allowing both comparisons across MCOs as well as meaningful aggregation across the entire program. That analysis is currently underway but has not been completed for the submission of this quarterly report.

Fiscal Issues

During this reporting period, HSD continued making MCO payments and completed nine months of capitations. However, HSD has decided to re-process capitation payments that were made for January through June and is currently in the process of making these adjustments. As previously reported, mid-year rate changes were made with a retroactive impact to January and the retroactive payments for January through June were initially made as lump sums. HSD is currently reprocessing those months in order to better action capture the historical capitation payments and tying them directly to member enrollment. This re-processing should be completed by the end of this calendar year.

An additional rate change took place in July to incorporate a legislatively mandated rate increase for nursing facilities and personal care services.

Systems Issues

HSD identified NF LOC and setting of care (SOC) issues that impacted all four MCOs. These issues were due to multiple files interfacing with multiple systems and confusion around that process. HSD receives NF LOC information from the MCOs but different interfaces are used to update the NF LOC information to the MMIS and ASPEN. There was confusion from the MCOs on which interface updated which system and that once one system was updated, it would update the other system. HSD has conducted web training as well as onsite training with each of the MCOs to ensure that they have a clear understanding of the process.

HSD also identified an issue with patient pay amount differences between the MMIS and ASPEN. HSD has researched and analyzed this issue and identified that not all patient pay amounts are being sent from the eligibility system, ASPEN to the MMIS. A system fix is scheduled to be implemented in the fourth quarter.

System fixes for the eligibility issues impacting disenrollment that are addressed in Section II are scheduled to be implemented in the fourth quarter.

Section VII: Home and Community Based Services (HCBS)

Independent Consumer Support System

The New Mexico Independent Consumer Support System (NMICCS) 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 third quarter is provided by the Aging and Long-Term Services Department (ALTSD) Aging and Disability Resource Center (ADRC). The numbers below reflect calls made to the ADRC hotline from July 1 to September 30, 2014.

Table 4. ADRC Call Profiler Report

Topic	# of Calls
Home/Community Based Care Waiver Programs	1,597
Long Term Care/Case Management	114
Medicaid Appeals/Complaints	79
Personal Care	37
Transitional Case/Care Management	216
*State Medicaid Managed Care Enrollment Programs (New Topic beginning FY14 3rd Q)	34
*Medicaid Information/Counseling (New Topic beginning FY14 3rd Q)	977

*To enhance the ADRCs Call Profiler Reporting and assist the NMICSS data collection effective July 1, 2014, the ADRC added new topics to its Call Profiler Reporting.

The numbers below reflect counseling services provided by the ADRC Care Transition Program from July 1 to September 30, 2014.

Table 5. ADRC Care Transition Program Report

Counseling Services	# of hrs	# of Nursing Home Residents	# of Contacts
Transition Advocacy Support Services		96	
Medicaid Education/Outreach	1034		
Medicaid Options/Enrollment	154		
Pre/Post Transition Follow-up Contact			**1253

** Eighty-nine percent (89 percent) of the contacts are pre-transition contacts and the remaining eleven percent (11 percent) are post transition contacts. These numbers are resident specific and situation dependent.

The ADRC provided the following reasons for changes in numbers since the last quarterly report:

- The Care Transition Bureau (CTB) has continued to see a significant increase in referrals this quarter. Caseloads within the program continue to grow statewide.
- The CTB has seen a decrease in facilitating Medicaid eligibility as the majority of individuals referred to the program are already enrolled in Medicaid. In addition, the role of the MCOs in Centennial Care includes direct responsibility for assisting members in applying for the Community Benefit. This quarter, the CTB has seen a significant decrease in assisting with eligibility as the MCOs have integrated this responsibility more fully into their scope of work, thus relying less on CTB to be directly involved with this process.
- The CTB continues to see a significant increase in education, outreach and advocacy efforts. This is partly due to the growing number of individuals receiving care transition services as well as the continued need for education regarding Centennial Care and other community benefits to facilities, MCOs and other service providers, consumers, families and other stakeholders.

HSD continues to work with the partners of the NMICSS to assist in understanding the types of questions and issues Centennial Care members may have when utilizing LTSS and whether the NMICSS is meeting its intended purpose. The Ability Center in Las Cruces is the newest partner of the NMICSS. The NMICSS Advisory Team created a tracking form for volunteers and counselors who assist Centennial Care members seeking information about care coordination, grievances and appeals and general questions members may have with their LTSS.

Critical Incidents

During the third quarter, HSD has made system improvements to better address the reporting of incidents from BH providers with more accuracy. Report #36 (Critical Incidents) is completed and submitted monthly and quarterly by each MCO. This data is trended and analyzed by HSD.

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

- Ongoing bi-weekly meetings continue with the MCOs and HSD to discuss issues and concerns about the critical incidents reporting process. Issues addressed this quarter included direction for BH providers in a written protocol by BHSD to the MCOs. The MCOs will notify providers and train them in the implementation of new protocols. Other areas of focus have been clarification around the definition and reporting of environmental hazards and HSD's requirements for the review of reported unexpected deaths.

- Opportunities for improving systems and preventing future harm have been discussed in the critical incident workgroup. A current issue is assuring that individuals with BH challenges get the attention needed to successfully maintain health and safety. The workgroup has found that more than one-third of the reports submitted by providers who are not BH providers include a diagnosis of mental health (MH) conditions or the incident indicates MH conditions may be present. About 10 percent of the reports submitted to the portal do not include a diagnosis and this data gap could be significant. The workgroup aims to decreasing the number of reports with no diagnoses. This is done by requiring the MCO to add diagnosis information to the report if that data is available. Each MCO shares incidents with their internal BH units for review and appropriate follow-up. The next stage in this project is to identify training supports to be provided for caregivers who work with members who live with mental illness to improve the delivery of HCBS and outcomes for these members.
- In addition to the ongoing collaborations identified in previous quarterly reports, the HSD Critical Incident Unit shares information with other state staff when a system issue is identified. In the third quarter, HSD SDCB staff received training on the web portal and its functions and was given access to the site so they can better monitor the recipients in self-direction who have critical incidents.
- Daily review of incident reports is conducted by the MCOs and HSD. Quality of reporting by providers and the documentation of follow-up by the MCOs has improved. During the reporting period, UHC needed increased technical assistance with reporting. As a result, the state required an intensive four week review of all incidents submitted by UHC with weekly telephone conferences to review each concern. UHC failed to sufficiently improve performance with focused technical assistance and was required to submit an action plan to HSD. HSD will monitor the action plan and will conduct an on-site audit when UHC demonstrates improvement prior to closing the action plan.
- A quarterly review of all deaths submitted through the HSD critical incident web portal is conducted. HSD clinical staff reviews decedent data and consults on mortality cases and complex cases**.** In the third quarter, there was one homicide and one suicide. Both deaths were investigated by the appropriate authorities and are under review by the MCOs. These two deaths did not occur during authorized services or while the member was in a facility. Of the remaining 35 unexpected deaths, 15 have been reviewed and determined expected. The remaining 18 deaths are being investigated by the police or the Office of the Medical Investigator and by the MCOs. Four of the deaths occurred during authorized service hours; none of those four deaths raised concern about the care or services provided to the recipient.

In the third quarter, the web-based system supported over 2,307 users statewide (up from 1,500 last quarter). The database managed more than 3,319 reports with 2,887 monitored for follow-up.

Table 6. Quarter 3 Critical Incident Data

Critical Incident Types	All Centennial Care		Behavioral Health Related		Self-Directed Related	
	#	percent	#	percent	#	percent
Abuse	282	10%	93	34%	21	9%
Neglect	303	11%	20	7%	20	9%
Exploitation	132	5%	2	1%	21	9%
Death						
Natural/Expected	229	8%	4	1%	18	8%
Unexpected	37	1%	2	1%	5	2%
Homicide	1	0%	1	0%	0	0%
Suicide	1	0%	0	0%	0	0%
Elopement/Missing	34	1%	22	8%	0	0%
Emergency Services	1685	58%	95	35%	125	56%
Environmental Hazard	53	2%	1	0%	1	0%
Law Enforcement	126	4%	35	13%	13	6%
Total	**2883**	**100%**	**275**	**100%**	**224**	**100%**

HSD is developing more expertise at utilizing incident data to respond timely and effectively to issues and concerns. A project to improve the identification and response for members with BH needs who receive personal care and other HCBS is described above. Identifying members with multiple reports continues to be an effective intervention as described in the second quarter report. The result of identifying incidents that occur outside authorized hours for HCBS continues to provide information to MCOs that allow for more timely and individualized responses. As available data increases, there will be better analysis of those issues that impact health, safety and service delivery. This leads to more opportunities for system improvements and improved individual outcomes.

Community Benefit

Quality assurance monitoring activities related to the Community Benefit (CB) in the quarter included working with care coordinators to resolve SOC systems issues (see Section VI).

Participant-Centered Planning and Service Delivery

Any LTC care plans, including those for HCBS, which were not considered patient-centered during the care coordination desk audits, are noted in the Care Coordination Audit Reports (see Section VI).

Health and Welfare

There were some findings in the care coordination desk audit which are related to health and welfare. Follow-up for “fall hazards” and discharge plans may have occurred but were not always documented in members’ files.

Self-Directed Community Benefit

On August 12, 2014, HSD and Self-Directed Community Benefit (SDCB) staff conducted an in-depth training for all care coordinators and support brokers to review the operation and implementation of SDCB. The training resulted in better collaboration between support brokers and care coordinators to address SDCB members' needs. Since the training, care coordinators are asking pertinent questions and demonstrating a broader understanding when HSD staff reaches out to them to discuss issues.

HSD continues to work with the care coordinators to ensure timely completion of annual NF LOC determinations and SDCB care plans. There have been several instances where the SDCB budget was not entered timely and thus created a delay in the annual SDCB care plan development and approval. These occurrences are discussed and resolved with the care coordinators during a regularly scheduled weekly call.

Section VIII: AI/AN Reporting

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 Indian Health Services (IHS) and Tribal 638 clinics at any time. Please see Attachment B for I/T/U GeoAccess reporting

Contracting Between MCOs and I/T/U Providers

In this reporting period there were no new contracts between the MCOs and Urban Indian (I/T/U) providers. The MCOs continue to reach out to I/T/Us to develop provider agreements, and there is a positive relationship between the entities. IHS, Tribal health providers, and I/T/Us are not required to contract with the MCOs under Centennial Care.

Timely Payment for All I/T/U Providers

All four MCOs met timely payment requirements ranging from 95 percent to 100 percent of claims being processed and paid timely. This is an increase from last quarter (90 percent to 97 percent).

Table 7. Issues Identified and Recommendations Made by the Native American Advisory Board (NAAB) and the Native American Technical Advisory Committee (NATAC)

MCO	Date of NAAB Meeting	NAAB Issues/Recommendations
BCBS	Ohkay Owingeh, NM 8/20/14	BCBS answered questions about transportation services, how to receive value added benefits (ie. traditional healing) and the importance of members completing their HRA. There were four members in attendance at the meeting. BCBS will continue to work on increasing attendance.
MHNM	Bernalillo, NM 07/02/14	MHNM answered questions about Centennial Care, specifically how to access care coordination and other healthcare services. They also stressed the importance of members completing their HRA. Fifteen members were in attendance.
PHP	Ohkay Owingeh, NM 09/10/14	PHP explained the traditional healing benefit. HRAs were available at the meeting for members to complete and PHP discussed future outreach events that will offer HRAs. About 12 members were in attendance.
UHC	Gallup, NM 09/04/14	Logisticare, the transportation vendor for UHC, discussed their services and issues they have had lately since another vendor in the area stopped

	providing transportation. There were two providers present at the meeting. There were no members present. UHC will continue to work on increasing attendance.

The last NATAC meeting for this quarter was on September 15, 2014. Nine members were present. The meeting included discussion on current enrollment numbers for Native Americans, the number of Native Americans in Centennial Care vs. FFS, processing timelines for Medicaid applications, MCO provider agreements with I/T/Us, and how Native American members in Centennial Care can earn reward points for healthy behaviors.

Section IX: Action Plans for Addressing any Issues Identified

Action plans are requested from the Centennial Care MCOs when HSD identifies an issue and has had discussions on the issue with the MCO. Action plans are requested so that HSD is able to monitor the MCOs' internal processes. For the third quarter, MCOs have updated their ongoing internal action plans; removed completed plans; and, added new plans that were initiated during the quarter (see Attachment D). Please note that HSD did not impose any Directed Corrective Action Plans (DCAPs) on any of the MCOs during the reporting period.

Section X: Financial/Budget Neutrality Development/Issues

As mentioned in Section VI, the MCOs have now submitted comprehensive financial reports for the first three quarters. Additionally, the MCOs are nearly up-to-date and complete in their submission of encounter data. This allows HSD the ability to verify information contained in financial reports.

HSD continues to monitor eligibility and enrollment trends with an eye toward budget neutrality. The system issues mentioned in previous reports that led to a significant retro-active changes has begun to slow and HSD has been able to gain a clearer picture of current enrollment under Centennial Care as well as what we believe are more accurate projections for future years. Some of the issues noted in the last report – mis-alignment of MEGs 2 through 5, have been corrected for this quarter's budget neutrality submission.

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.

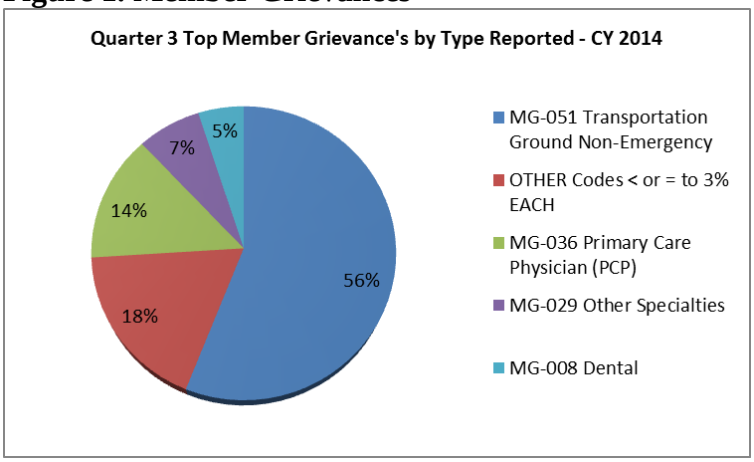
Table 8. Member Months

Eligibility Group	Member Months
Population 1 – TANF and Related	1,117,219
Population 2 – SSI and Related – Medicaid Only	117,258
Population 3 – SSI and Related – Dual	98,106
Population 4 – 217-like Group – Medicaid Only	6,954
Population 5 – 217-like Group – Dual	13,787
Population 6 – VIII Group (expansion)	509,751
Total	1,863,075

Section XII: Consumer Issues (Complaints and Grievances)

A total of 817 member grievances were filed by all four MCOs' members in the third quarter. Ground transportation non-emergency benefits constituted the largest number of grievances with 312 (56 percent) of the 556 grievances in the top three categories reported by all MCOs.

Figure 1. Member Grievances



MCOs reporting the largest number of transportation non-emergency grievances were BCBSNM with 122 reports (67 percent of their total grievances received), and UHC with 157 reports (76 percent of their total grievances received).

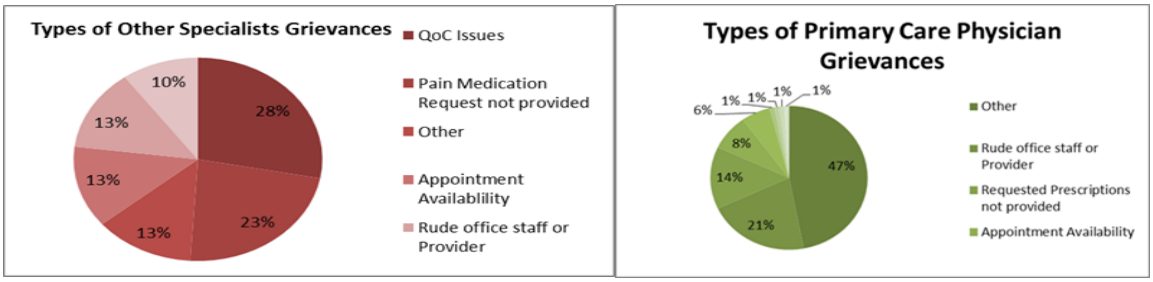
BCBSNM has monitored transportation non-emergency concerns through an action plan with its vendor, which has shown a decrease in transportation grievances by 57 percent from August to September.

UHC implemented an action plan to examine and address the growing number of transportation non-emergency grievances in September. In October, UHC's transportation related grievances showed a slight decrease of 18 percent from UHCs transportation non-emergency grievances reported in August.

The other category of grievances (18 percent of total grievances) consisted of a variety of types; with each type constituting less than 3 percent of any specific type of issue and included 97 reports. This small percentage of the total grievances did not show any specific trends.

In the PCP grievances category, members reported rude staff or providers (21 percent). Other grievances were largely concerns with quality of care (28 percent) that MCOs addressed through their internal processes in addition to concerns by members requesting pain medications that providers were unable to determine as medically necessary (23 percent).

Figure 2. Types of Specialists and PCP Grievances



Section XIII: Quality Assurance/Monitoring Activity

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

Table 9. NF LOC Audit Quarterly Totals

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

Table 10. Denied Requests for NF LOC

Community benefit denied requests due to denial of NF LOC	**Quarter 1 2014**	**Quarter 2 2014**	**Quarter 3 2014**
# of member files audited	36	53	14
# of member files that met the appropriate level of care criteria	36	53	14
percent of MCO level of care determination accuracy	100%	100%	100%

Section XIV: Managed Care Reporting Requirements

MCO Reporting Process

The MCO data reporting requirements include: monthly, quarterly, semi-annual, annual, and ad hoc reports. Each MCO is required to submit approximately 95 reports to HSD annually. During the third quarter, the Daily Call Center Report was discontinued due to consistent MCO compliance. Additionally, HSD continued its efforts of evaluating the report review and analysis process.

In August, HSD facilitated report revision work sessions consisting of program and subject matter experts. Recommendations from MCOs and state staff were considered and incorporated. This process ensures that the MCOs submit meaningful data for HSD to use in monitoring and measuring the success of Centennial Care. Ongoing evaluation of report requirements will continue; another work session is scheduled in October.

BH Reports

During the reporting period, the Centennial Care utilization report (report #41) was revised. Due to the revised report, the MCOs will submit utilization data for the third quarter in December 2014. Utilization data for the third quarter will be provided in the next quarterly report.

Network Adequacy

Please refer to Section II for information related to network adequacy.

Customer Service Reporting

Call Center Metrics

BCBSNM, MHNM and PHP all met, or exceeded, contract standards for all customer service lines from June 2014 through August 2014.

UHC met all contract standards for all customer services lines except the provider services line. One hundred percent (100 percent) of voicemails are required to be returned by the next business day; however, UHC reported 92.9 percent (13 out of 14 voicemails) returned in June. UHC met the 100 percent standard in July and August.

UHC had been out of compliance with reporting nurse advice line warm transfers. Its call system software was unable to accurately identify the number and reasons for transfers from January until June 2014. Implementation of an action plan was necessary (see Section IX and Attachment D). Beginning July 2014, UHC began capturing and reporting nurse advice line warm transfer data.

Appeals

A total of 532 appeals were filed by members of all MCOs in the third quarter. Of the total appeals filed, 349 (66 percent) have been upheld, 113 (21 percent) have been overturned and the remainder are pending resolution. Appeals have been processed in a timely manner by the MCOs.

Denial or limited authorization of a requested service continues to be the reason for the majority (87 percent) of appeals. HSD has requested further analysis on reasons and potential trends related to appeals from the MCOs and any findings will be reported in the next quarterly report.

Section XV: Demonstration Evaluation

In the reporting period, CMS provided HSD with a verbal approval of the Evaluation Design Plan with a formal acceptance letter to follow. HSD began contract negotiations with the selected vendor on Friday, August 29, 2014. Currently, HSD is in the procurement process and no public information has been released regarding this tentative award. Formal notification of award will follow after successful completion of the final contract.

Section XVI: Enclosures/Attachments

- Attachment A: Budget Neutrality Tables (July 1, 2014 – Sept 30, 2014)
- Attachment B: GeoAccess Report for Physical Health (Q2FY14)
- Attachment C: GeoAccess Report for Behavioral Health (Q2FY14)
- Attachment D: Action Plans
- Attachment E: PHP ER Diversion Project

Section XVII: State Contacts

HSD Staff Name and Title	Phone Number	Email Address	Fax
Julie Weinberg Director HSD/Medical Assistance Division	(505)827-6253	Julie.Weinberg@state.nm.us	(505)827-3185
Nancy Smith-Leslie Deputy Director HSD/Medical Assistance Division	(505)827-7704	Nancy.Smith-Leslie@state.nm.us	(505)827-3185
Matt Onstott Deputy Director HSD/Medical Assistance Division	(505)827-6234	Matt.Onstott@state.nm.us	(505)827-3185
Angela Martinez Bureau Chief for Centennial Care HSD/Medical Assistance Division	(505) 827-3131	AngelaM.Martinez@state.nm.us	(505)827-6263

Section XVIII Additional Comments

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

Centennial Care Member Success Story 1

As a MCO care coordinator spoke with members of the Navajo Nation, she was approached by a gentleman. He had overheard that she was working for one of the MCOs; the member stated he had received a Centennial Care membership card in the mail and asked what the card was for. As she spoke with the individual, she realized he was not familiar with the benefits that were available to him. She showed him the customer service number on his card and informed him of the variety of services available. She conveyed the necessity of taking advantage of the benefits, especially care coordination. As they spoke about this, the member stated he had been very concerned about his weight and his heart health. He said he wanted to go in for a visit to the hospital to get an honest appraisal of his health. During this discussion, it became apparent that this individual was experiencing some symptoms that needed to be addressed. As they spoke she let him know about supportive elements available for his medical follow-up. He commented that that this process sounded more involved and supportive than he was familiar with (IHS). She showed him the link to the MCO's website on her phone and let him know that the chapter houses had internet services that could be used to access the MCO's supportive services. She also let him know that there are Navajo speaking care coordinators, who are able to help him in his native language as he needed. This individual was able to follow-up on his appointment and found he needed immediate treatment for hypertension, and overall cardiac care. Centennial Care and the benefits made such a positive impression that the member took the initiative to seek medical follow-up, most likely saving his life.

Centennial Care Member Success Story 2

A member was showing signs of depression and was taking medication prescribed by her PCP, but this member was adamant about not wanting to go to therapy or see a counselor. The member felt she could "get by" with being around family and friends. She did not like to be alone and would become very discouraged when she was by herself thinking that no one wanted to be around her. The care coordinator brought up the possibility of the member talking with someone just to see how it would go, but the member continued to refuse to make an appointment for counseling. Several months later the care coordinator received a call from a home care agency who had received a report that the member was suicidal. Through the care coordinator's immediate contact with the member, an incident report was filed with follow-up and peer support was offered in an attempt to open the doorway for the member to begin seeing a counselor. The member finally agreed to give therapy a try, and she is finally getting the help that she needs.

Centennial Care Member Success Story 3

Upon completing a CNA, the member became tearful and stated that she wanted a psychiatric evaluation. She stated that she was afraid that she might overdose on pills that evening if she continued to suffer from insomnia and depression. The member stated "I want to go to the hospital and get help. I won't hurt myself. I want to get help." The member's mother drove the member in her car and the care coordinator drove ahead so they could follow her, as they were unsure of how to get to the hospital. The member and her mother arrived safely, and the member requested that the care coordinator walk in with her, which she did. The member completed an intake form and was taken in for an evaluation.

This member has endured poverty since childhood, married and became estranged from her spouse, and is now faced with accepting her illness. She has the spirit and desire to become employed. However, her physical illness ailments prevent her from seeking and finding employment. The member applied for food assistance and Medicaid. The Affordable Care Act and New Mexico's expansion of Medicaid provided her with the opportunity to receive health insurance.

The MCO's care coordination team assessed the member, coordinated care and assisted the member in receiving personal care services (PCS). PCS were approved for the member to provide assistance needed in her home, shopping for groceries, and running errands such as picking up her medications. The member is now empowered to utilize transportation and lodging for appointments long distance. Her first appointment with a Pulmonologist in Albuquerque traveling from her rural home town was a success. The member has an identified PCP medical home to address her medication management and HEDIS alerts. She is greatly appreciative of the services the Centennial Care provides for her.

Centennial Care Member Success Story 4

A member who was the victim of a drive-by shooting several years ago became eligible for Centennial Care through the Medicaid expansion. Her sister wrote a heartfelt thank you letter to the Centennial Care MCO.

One of the major road blocks the member had encountered in the past was trying to get someone to help her in her home. For a period of time her family was able to pay out of pocket for her care. However, this became too expensive. The outcome of this was that the member had not had any help for the last 10 months prior to being enrolled in Centennial Care.

The member was recently approved for Medicaid due to the expansion. Her sister spoke to the Centennial Care MCO's benefits department and they suggested that the sister ask for a care coordinator to help her with the member's needs. The care coordinator worked endless hours asking the sister questions to determine the member's needs. She worked with the member's doctors and physical therapists to make sure all appropriate papers were received from them.

She made sure all the paperwork was done correctly so that the member's case could be efficiently reviewed.

The care coordinator also accommodated the sister with her work hours, since she resides in another state. The sister wrote "I have no doubt that it was because of her relentless efforts that (the member) was finally able to receive the home care that she has desperately needed. There will never be enough words to express the heartfelt gratitude I feel."

The sister reports that she is at ease knowing her sister is getting the care she needs and the member is happy with her caregiver.

End Notes

1. US Department of Health and Human Services: Health Resources and Services Administration (HRSA), Retrieved from: http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/.

2. New Mexico Department of Health, (2014). Retrieved from: http://nmhealth.org/news/information/2014/9/?view=130.