Centennial Care Waiver Demonstration

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

5/30/2014
Submitted by:
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 20% of the State's total General Fund budget each year. In State Fiscal Year 2012, New Mexico and the federal government spent approximately four billion dollars on Medicaid services for New Mexicans. With the Governor's decision to expand Medicaid to newly eligibles beginning in January 2014, the State projected an addition of approximately 170,000 new enrollees to the program by June 2015. All of these factors, combined with rising program costs, necessitated modernization of the Medicaid program.

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

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

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

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

The culmination is the development and implementation of Centennial Care, a comprehensive, integrated delivery system for Medicaid that integrates physical, behavioral and long-term care services; ensures cost-effective care; and focuses on quality over quantity.

Key Dates

In August 2012, HSD submitted its Section 1115 demonstration waiver proposal to the Centers for Medicare & Medicaid Services (CMS) and released its competitive procurement to secure the

Section II: Enrollment and Benefits

Eligibility

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

Enrollment

Centennial Care enrollment has continued to increase each month in the first quarter. Expansion of Medicaid eligibility as described above has contributed to the overall increase in enrollment. The majority of Centennial Care members are enrolled in Population 1- TANF and Related with Population 6- Group VIII (expansion) being the next largest group as reflected in Section III of this report.

Disenrollment

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

Access

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

Service Delivery

Care coordination is one of the key changes implemented in Centennial Care that ensures effective service delivery. Previously, all services were provided separately with no formal collaboration between providers. Care coordination utilizes a model similar to case management where members who are at the highest risk for poor health outcomes are guided through the system by a care coordinator and are assigned to a care coordination level 2 or 3, based on their assessment results. Care coordinators then focus on developing personalized plans for members that ensure all the necessary services needed are coordinated collaboratively with the member and provided in a timely manner. This model ensures that members have one point of contact for all of their physical and behavioral health needs, providers are aware of services and medications received from other physicians, and member-centric plans of care. According to the Centennial Care contract, MCOs are required to conduct the health risk assessment (HRA) within 30 calendar days of new member enrollment and 180 calendar days of enrollment for transitioning members from legacy Medicaid programs.

care and transportation providers, but the lack of certain specialties (≤90%) was identified in some areas of the State, especially in the rural and frontier areas.

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

During weekly calls with each MCO, HSD reviewed the MCO networks and contracting status, including contracting status with Core Service Agencies (CSAs) for behavioral health services.

MCOS are not required to contract with Indian Health Services Tribally Operated and Urban Programs (I/T/Us). All MCOs are required to allow members to access care at I/T/Us and to reimburse the I/T/Us at the Office of Management and Budget (OMB) rate.

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

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

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

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

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

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

costs to Medicaid. The use of CIs aligns with the care coordination activities outlined in Centennial Care and the use of these individuals provides a specialized skill set and qualifications for members.

Minimum provider qualifications for a CI:

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

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

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

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

A total of 521,105 members were assigned to a Centennial Care MCO in the quarter. Of that total, 388,366 members chose an MCO. This count includes members who transitioned from the SALUD or CoLTS program and who stayed in their SALUD or CoLTS MCO. It is important to note that, for care continuity purposes, members enrolled in a CoLTS or SALUD MCO that became a Centennial Care MCO automatically stayed in their MCOs unless they actively

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.

Demonstration Population	Total Number of Demonstration Participants Quarter Ending – March 2014	Current Enrollees (Year to Date)	Disenrolled in Current Quarter
Population 1 – TANF and Related	375,556	375,556	21,186
Population 2 – SSI and Related – Medicaid Only	39,268	39,268	822
Population 3 – SSI and Related – Dual	32,877	32,877	965
Population 4 – 217-like Group – Medicaid Only	2,306	2,306	80
Population 5 – 217-like Group – Dual	4,589	4,589	95
Population 6 – VIII Group (expansion)	125,523	125,523	5470
Totals	580,119	580,119	28,618

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

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

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

- Member rewards program
- Tracking out-of-pocket expenses
- Member materials
- Marketing materials
- Associated processes
- Safety net care pool
- Community interveners
- Fiscal management agency (SDCB) contract
- Encounter requirements (in addition to separate weekly systems meetings that continue)
- Nursing facility rates – high nursing facility (HNF) rates and low nursing facility (LNF) rates
- Transitional PAs
- MCO selection and open enrollment
- Network adequacy
- Deadlines for MCO deliverables
- Value added services
- Contract amendment
- Identified HSD Centennial Care Command Center (C4) process and MCO process

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

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

Centennial Care Command Center

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

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

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

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

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

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

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

Attachment B depicts the types of issues and their numbers that arose during early implementation of Centennial Care and were documented on the issues log.

information, program experiences, innovative services and developments in the field. Over time, the meetings have improved communications between the MCO care coordinators and the providers' direct service staff.

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

Pharmacy

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

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

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

MCO Reporting Process

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

HSD's process for tracking MCO report submissions is as follows.

These reports were essential tools in the monitoring of MCO readiness and first quarter Centennial Care implementation/performance.

Weekly Status Update Ad Hoc Reporting

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

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

Electronic Visit Verification

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

The EVV System Will:

- Use landlines and/or GPS enabled mobile devices to track visits
- Be web-based and paperless
- Allow the provider to review the claim before confirming it for submittal

Providers, MCOs and HSD are working together to ensure EVV implementation is not disruptive to members and caregivers. This partnership will ensure a successful implementation of EVV, improving the member's access to care and quality of care.

Quality of Care

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

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

Approval and Contracting With New Plans

At this time, there are no plans to contract with new MCOs.

Health Plan Contract Compliance and Financial Performance Relevant to the Demonstration

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

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

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

- Failing to submit accurate transition report data for month of January 2014
- Failing to meet contractual call center service levels
- Failing to meet adequate provider network for nursing facility services in Eastern New Mexico
- Failing to assign transitioning members from legacy Medicaid programs to care coordination levels in a timely manner
- Violating HIPAA requirements by sending unencrypted email communication seven separate times

making to find them. Some of these efforts include use of contractors such as LexisNexis® to confirm contact information and using claims data. HSD will convene the MCOs in the next six weeks to develop a unified plan to find the unreachable members.

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

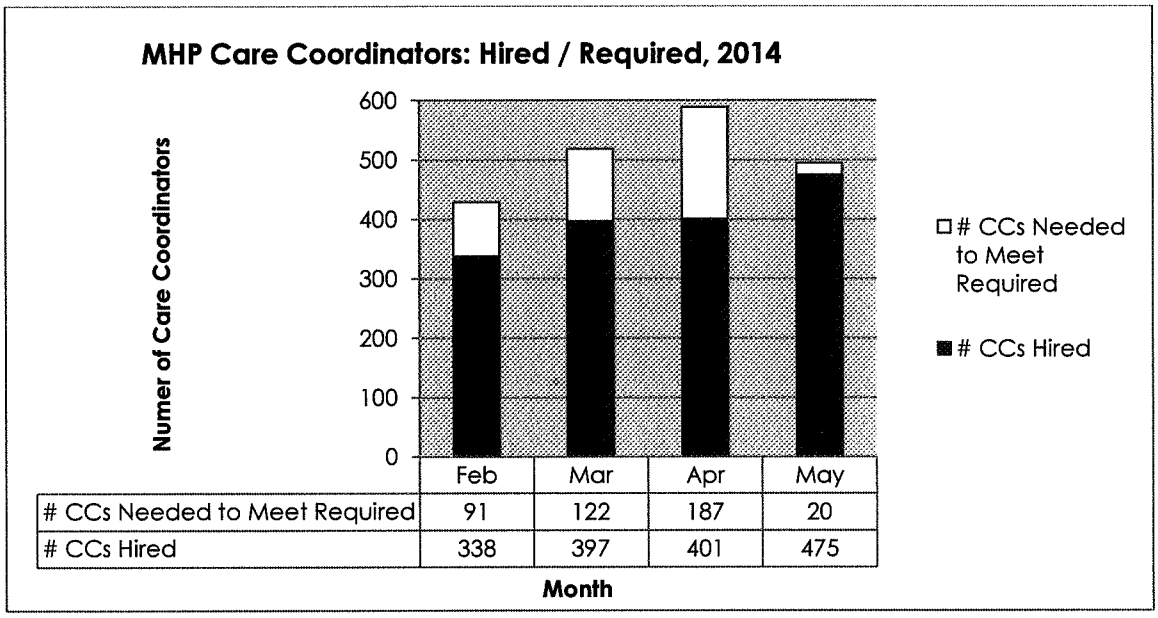
HSD monitors MCO care coordination activities to assure that sufficient care coordination is being delivered. HSD takes any necessary steps to ensure effective corrective actions are being implemented by the MCOs when needed. HSD staff also oversees care coordination through weekly technical assistance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

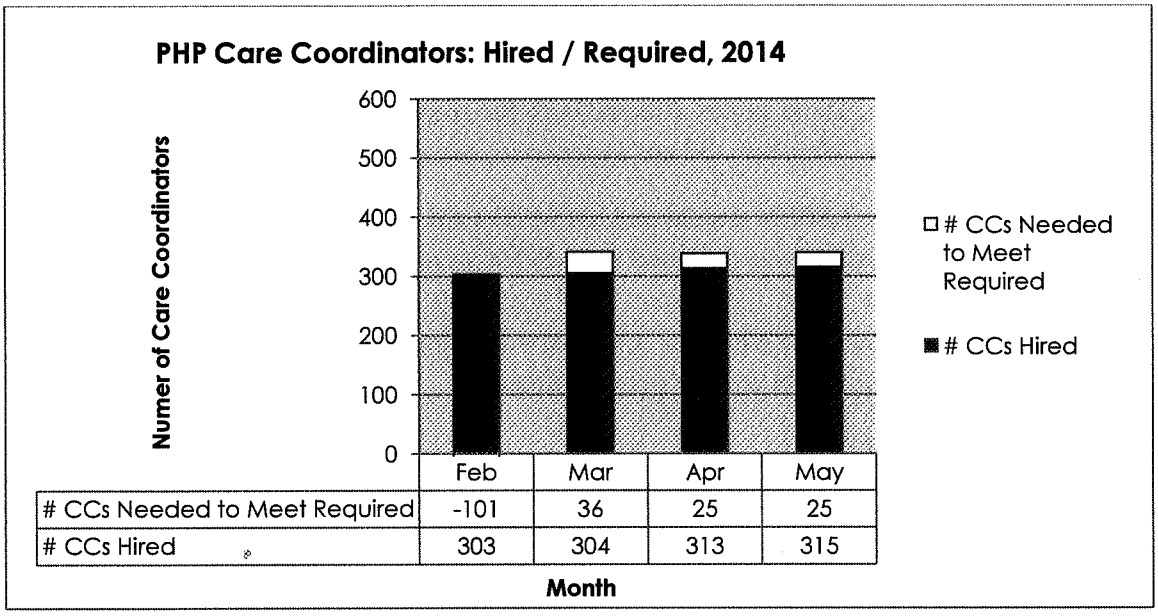
Challenges were encountered with one MCO being unable to operationalize and utilize their new care coordination system. As a result, data was unable to be uploaded from HSD and into their care coordination system. The MCO lost valuable time with the delay of this system implementation. It was unable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

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

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

Some nursing facilities experienced difficulties identifying who their residents' care coordinators were. Each MCO was directed to send its list of care coordinators with their contact numbers to the nursing facilities.


MHP Care Coordinators: Hired / Required, 2014
Numer of Care Coordinators
600
500
400
300
200
100
0
CCs Needed to Meet Required
CCs Hired
Feb
Mar
Apr
May
CCs Needed to Meet Required 91 122 187 20
CCs Hired 338 397 401 475
Month


PHP Care Coordinators: Hired / Required, 2014
Numer of Care Coordinators
600
500
400
300
200
100
0
CCs Needed to Meet Required
CCs Hired
Feb
Mar
Apr
May
CCs Needed to Meet Required -101 36 25 25
CCs Hired 303 304 313 315
Month

The MCOs' LOC determinations are under a dual review process. HSD's External Quality Review Organization (EQRO) conducts ongoing random reviews of LOC determinations to ensure that the MCOs are using the New Mexico criteria, process and tools consistently. The focus is on ensuring that the MCOs apply the criteria consistently across the population and that the members met the requirements for services. In addition, HSD/MAD Quality Bureau (QB) randomly reviews denials to ensure that they were appropriate based on the requirements.

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

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

Provider Issues

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

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

Service Plans

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

During this reporting period, seven reductions were requested by the MCOs. After review, the QB approved two of these requests for reductions. The reductions were approved because the members no longer met the minimum requirements of two activities of daily living in order to receive long-term services and supports (LTSS).

Section VII: Home and Community Based Services (HCBS)

Independent Consumer Support System (ICSS)

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

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

ADRC Call Profiler Report

Topic	# of Calls
Home/Community Based Care Waiver Programs	2,649
Long-Term Case/Care Management	102
Medicaid Appeals/Complaints	109
Personal Care	101
Transitional Case/Care Management	96

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

ADRC Care Transition Program Report

Counseling Services	# of Hours	# of Nursing Home Residents	# of Contacts
Transition Advocacy Support Services		37	
Medicaid Education/Outreach	98		
Medicaid Options/Enrollment	436		
Pre/Post Transition Follow-up Contact			508*

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

Critical Incidents

HSD operates a web-based critical incident reporting system to receive, track and trend critical incidents occurring within the HCBS populations and recipients receiving behavioral health services. Providers of Centennial Care services, including HCBS; long-term care, and self direction are directed to establish access to this system and to report incidents into the system within 24 hours of knowledge of the incident. Providers are also directed to report to New

Explain

The following table reports specific data collected in the first quarter of Centennial Care.

Critical Incidents - Primary Incident Type						
Critical Incident Types	Centennial Care	Centennial Care Percent per Incident Type	Behavioral Health	Behavioral Health Percent per Incident Type	Self Directed	Self Directed Percent per Incident Type
Abuse	227	11%	70	32%	20	8%
Neglect	169	8%	12	6%	11	4%
Exploitation	81	4%	1	0%	8	3%
Environmental Hazard	41	2%	1	0%	8	3%
Emergency Services	1223	58%	56	26%	176	68%
Law Enforcement	115	5%	48	22%	4	2%
Elopement/Missing	17	1%	14	6%	1	0%
Death						
Natural/Expected	190	9%	8	4%	25	10%
Unexpected	58	3%	5	2%	6	2%
Homicide	3	0%	0	0%	0	0%
Suicide	1	0%	1	0%	1	0%
Total Number of Critical Incidents	2125	100%	216	100%	260	100%

Systemic Community Benefit Issues

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

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

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

Self-Direction of Benefits

For the first 120 days of Centennial Care, the Self-Directed Community Benefit (SDCB) membership consisted of 960 individuals who transitioned from the Mi Via waiver. The SDCB population is not expected to grow until the ABCB recipients have been enrolled in the ABCB for at least 120 calendar days; May 1, 2014 is day 121. HSD anticipates that the most likely recipients to switch to SDCB will be some of those who transitioned to ABCB from Personal Care Services under the CoLTS program (prior to January 1, 2014).

Section VIII: AI/AN Reporting

Access to Care

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

Contracting Between MCOs and I/T/U Providers

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

Ensuring Timely Payment for All I/T/U Providers

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

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

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

Section IX: Action Plans for Addressing Any Issues Identified

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

MCO	Action Plan Name	Description	Date of Implementation
All MCOs	Unreachable Members	Based on lists of unreachable members submitted by all MCOs, HSD staff attempted to contact 25 members per week from each MCO for four consecutive weeks. HSD has plans to do innovative campaigns which would include booths at public spaces, member rewards for completing HRAs, coordinating with Income Support Division, school based clinics and other state agencies to facilitate reaching unreachable members. HSD has shared all enrollment files with the MCOs and has closely monitored the MCO's activities toward decreasing the number of unreachable members.	03/10/2014
BCBS	UM Intake Line	Increase % of calls answered within 30 seconds for UM Intake during Centennial Care start up by optimizing schedules, reviewing Customer Advocate activities during peak call hours, and increasing employees.	2/14/2014
BCBS	Provider Tri County	Tri County reported that they were experiencing claims payment issues; HSD held weekly meetings for five weeks until the issues were resolved. HSD now touches base with the provider on an as needed basis.	2/25/2014
BCBS	CNA Revision	Revisions were made to the CNA template to facilitate a better member experience and to maximize efficiencies.	3/6/2014
BCBS	PCP Auto-Assignment	Correction to PCP Auto-Assignment logic to allow members 15 days to select a PCP prior to assigning one.	3/18/2014
BCBS	Community Benefit Services Plan Monitoring	A plan was developed to improve the results of review of the community benefit services plans by ensuring all care plan goals and safety and health needs were met. As part of the plan, system issues and barriers were identified and mitigated and a quality assurance process was implemented.	3/25/2014

PHP	PA	Improve turnaround time (TAT) performance for UM/PA and PA backlog:The PA team was divided into teams with one handling everything from 1/30/2014 and the other team handling everything earlier, the backlog was up to date on 2/4/2014. Improve UM queue performance (Call Center):Call center set up 4 staff dedicated to the UM call lines in addition had 4 regular staff also answering the phones. In January call service level was at 50%, in February service level was at 87.2% and has met the contractual requirement every month thereafter.	1/29/2014
PHP	Nurse Advice New Mexico	Action Plan to address % of PHP Centennial Care calls answered within 30 seconds in order to achieve contractual requirements for call center performance.	1/24/2014
UHC	NurseLine not meeting operational metrics	Action plan implemented to reprioritize the calls from Centennial Care in the call tree which brought more agents into the queue.	1/9/2014
UHC	PCP auto assignment changes	Change/delay PCP Auto-Assignment process until the 16th day from eligibility load date for newly effective members that have not selected a PCP and exclude Native American members from PCP Auto-Assignment process.	1/3/2014
UHC	HRA completion	Increase member HRA completion rate for Level 1 enrolled members.	3/1/2014
UHC	LOC backlog	Identified nursing home members who have not had a LOC determination as initial or continued custodial stay.	3/31/2014

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.

Eligibility Group	Member Month
Population 1 – TANF and Related	1,086,008
Population 2 – SSI and Related – Medicaid Only	116,149
Population 3 – SSI and Related - Dual	97,212
Population 4 – 217-like Group – Medicaid Only	6,731
Population 5 – 217-like Group - Dual	13,615
Population 6 – VIII Group (expansion)	321,237
Total	1,640,952

Section XIII: Quality Assurance/Monitoring Activity

Please refer to section VI, for information on quality assurance and monitoring. No quality of care issues have been identified by HSD in this reporting period.

Appeals

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

Complaints and Grievances

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

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

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

Critical Incident Reporting

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

Measures to Ensure Participant Protections

The MCOs are contractually required to ensure that all ANE incidents are reported to APS and CPS in a timely manner. This ensures those entities can investigate as needed. HSD monitors the

Section XV: Demonstration Evaluation

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

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

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

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

The member's world was now unfamiliar to him. He suffered memory loss from the trauma and medication side effects for pain and infection. Member now required total assistance and supervision for all activities of daily living. His once active lifestyle was now occupied with multiple therapies to relearn how to function with the prosthetic leg he now needed. His wife was always by his side. The couple is also the primary caregiver to their developmentally disabled son and to the member's elderly mother-in-law whose health was declining. Member's wife now found herself as the primary caregiver for three family members. She was overwhelmed, exhausted, and diagnosed with depression.

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

Centennial Care Member Success Story 3

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

Centennial Care Member Success Story 4

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

ATTACHMENT A

New Mexico Budget Neutrality Monitoring Spreadsheet

DY 1

Start Date: 01/01/2014

End Date: 12/31/2014

Quarter 1

Start Date: 01/01/2014

End Date: 3/31/2014

MEG01 TANF & Related	DY 01	DY1 QTR 1 - Actuals
MMs [1]	4,727,584	1,086,008
PMPM	$ 385.80	$ 270.20
Dollars [2]	$ 1,823,911,159	$ 293,437,566

MEG02 SSI & Related - Dual Eligible	DY 01	DY1 QTR 1 - Actuals
MMs	373,823	116,149
PMPM	$ 1,780.77	$ 1,541.53
Dollars	$ 665,692,378	$ 179,046,845

MEG03 SSI & Related - Medicaid Only	DY 01	DY1 QTR 1 - Actuals
MMs	508,700	97,212
PMPM	$ 1,763.90	$ 1,329.45
Dollars	$ 897,298,062	$ 129,238,359

MEG04 "217 Like" Dual Eligible	DY 01	DY1 QTR 1 - Actuals
MMs	27,935	6,731
PMPM	$ 1,776.90	$ 1,294.81
Dollars	$ 49,637,569	$ 8,715,376

MEG05 "217 Like" Medicaid Only	DY 01	DY1 QTR 1 - Actuals
MMs	5,841	13,615
PMPM	$ 4,936.92	$ 1,647.83
Dollars	$ 28,834,295	$ 22,435,176

MEG06 Medicaid Expansion	DY 01	DY1 QTR 1 - Actuals
MMs	1,632,968	321,237
PMPM	$ 577.87	$ 409.75
Dollars	$ 943,638,928	$ 131,626,259

Uncompensated Care Pool	DY 01	DY1 QTR 1 - Actuals
Total Allotment	$ 68,889,323	$ -

Notes:

1.) Member months as reported in the Centennial Care Section 1115 Quarterly Report, Section XI.

2.) Expenditures as reported on the CMS-64 for the March Quarter of FFY14 less IHS payments.

HUMAN SERVICES
DEPARTMENT

Susana Martinez, Governor
Sidonie Squier, Secretary
Julie B. Weinberg, Director

Mr. Bill Brooks
Associate Regional Administrator
Dallas Regional Office
Centers for Medicare & Medicaid Services
Department of Health & Human Services
1301 Young Street, Suite 833
Dallas, Texas 75202

May 30, 2014

Dear Mr. Brooks:

During our most recent §1115 Waiver Demonstration monitoring call, Rob Nelb requested that the New Mexico Human Services Department (HSD) submit an update regarding behavioral health (BH) services in the state. This letter represents our second update following the onsite visit that CMS conducted for New Mexico's BH Medicaid program last Fall (the first update was submitted on February 17, 2014).

Similar to the report from February, the data and information contained here are based on survey and qualitative methodologies. We are currently getting in place our standardized procedures for reporting from our Centennial Care managed care organizations (MCOs). Similarly, we are starting to receive encounter data on BH services and expenditures. In the future, it is HSD's intention to report on BH services under our Centennial Care program through the quarterly reporting process outlined in our approved Special Terms and Conditions. We believe that regular reporting as part of this standardized process will provide CMS with regular and more standard information. Beginning with the second quarter report (QE June 2014; report date August 30, 2014), HSD will be using a combination of MCO reports and encounter data that will present a picture of Medicaid BH services in the state..

CMS Request: Status of contracts between the Core Service Agencies (CSAs) and Managed Care Organizations (MCOs).

HSD Response: At this point, all four MCOs are contracted with all CSAs (including the "new" agencies).

CMS Request: Updated data relating to Behavioral Management Services (BMS). Please provide that data for each quarter following June 2013 to present.

HSD Response: Attachment A shows the numbers of consumers receiving services by each of the five new agencies for four different points in time - May 2013, Novermber 2013, February 2014, and April 2014. The table also shows the number of consumers receiving BMS for those points in time.

HUMAN SERVICES DEPARTMENT

As you can see in the table, the numbers of total consumers served increased by about 24 percent from May of 2013 to April. The numbers of current BMS consumers is at roughly 70 percent of the May totals, and are roughly equal to those reported in February. Keep in mind that these numbers are only those from the "new" New Mexico providers and do not represent total consumers across all providers. HSD does plan on reporting those numbers in future reports. As in each of these reports, some of these consumers may not be in the Medicaid program.

As we noted in our earlier update, there are several factors that contribute to lower BMS levels.

- BMS is a service that is intended to help consumers meet goals and then transition to a lower level of care. BMS numbers should not be static but reflect consumers moving to a lower level of care in the system.
- May 2013 numbers reflect consumers that were served by providers that were flagged for overutilization of certain services, including BMS. We expected a decrease in BMS as it became managed in a more clinically appropriate manner by the incoming agencies.
- The new New Mexico provider agencies provided trainings to their staff regarding BMS. These trainings focused on ensuring that proper levels of care were being provided to BMS consumers and that the service was not being over-utilized.

As mentioned in our earlier update, families receiving BMS services prior to the transition last Fall were able to continue receiving services based on their request. Additionally, BMS is being provided in all of the schools that were serviced previously by the previous agencies.

***CMS Request**: Please provide a description of the outreach efforts that have been implemented in order to contact those beneficiaries and families that had utilized services prior to transition had not returned to receive those same services and the results those efforts have yielded.*

HSD Response: HSD has a focus on addressing implementation issues related to the integration of behavioral health services in Centennial Care. HSD brings together high-level MCO behavioral health managers with the CEOs of the primary behavioral health providers (core service agencies) to work through implementation issues. The meetings began several months before Centennial Care go-live and continue on a bi-weekly basis.

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

For example, the Workgroup has an on-going discussion to distinguish between the responsibilities of providers in clinical assessments and treatment planning vs. the responsibilities of the MCOs in health needs assessments and coordination of member care. Another on-going discussion concerns credentialing and billing by peer support workers. The frequent meetings with MCO managers and

HUMAN SERVICES
DEPARTMENT

agency CEOs facilitate effective communication through the resolution of such issues.

Please contact Ellen Costilla with any questions that you and your staff may have in your review of the enclosed information. Ellen can be contacted at (505) 827-3180 or Ellen.Costilla@state.nm.us.

Sincerely,

Julie B. Weinberg
Director

Enclosures

Cc: John O'Brien, CMS, Central Office
Barbara Edwards, CMS Central Office
Carey Appold, CMS Central Office
Stacey Shuman, Region VI Office
Linda Joyce, CMS Central Office
Michael Duffy, SAMHSA
John Campbell, SAMHSA
Karen Meador, HSD/Behavioral Health Services Div.
Robert Chavez, HSD/Behavioral Health Services Div.
Matt Onstott, Deputy Director, HSD/Medical Assistance Div.

HUMAN SERVICES DEPARTMENT

Attachment A – Consumers Receiving Services by CSA

Agency	Total Consumers Served (May)	BMS Consumers (May)	BMS Consumers (Nov 20, 2013)	Total Consumers Served (Feb 2014)	BMS Consumers (Feb 2014)	Total Consumers (April 15, 2014)	BMS Consumers (April 15, 2014)
Agave							
Agave	393	0	n/a	507	n/a	n/a	n/a
Agave	512	0	n/a	690	n/a	n/a	n/a
Agave	2694	582	By Community:	1557	By Community:	2983	By Community:
Santa Rosa	unavailable	unavailable	22	unavailable	18	unavailable	17
Raton	unavailable	unavailable	22	unavailable	26	unavailable	29
Las Vegas	unavailable	unavailable	23	unavailable	27	unavailable	33
Rio Rancho	unavailable	unavailable	42	unavailable	44	unavailable	51
Espanola	unavailable	unavailable	24	unavailable	34	unavailable	27
Clayton					19	unavailable	17
Farmington					2	unavailable	2
Grants	unavailable	unavailable	9	unavailable	6	unavailable	4
Los Lunas	unavailable	unavailable	27	unavailable	27	unavailable	26
Santa Fe	unavailable	unavailable	46	unavailable	47	unavailable	64
Taos	unavailable	unavailable	24	unavailable	25	unavailable	28
Total:	**3599**	**582**	**239**	**2754**	**275**	**2983**	**298**
La Frontera							
La Frontera	690	0	n/a	unavailable	n/a	below	n/a
La Frontera	517	41	below	unavailable	below	below	below
La Frontera	989	7	below	unavailable	below	below	below
La Frontera	257	37	below	unavailable	below	below	below
La Frontera	462	0	n/a	unavailable	n/a	below	n/a
La Frontera	noted above	noted above	below	unavailable	below	below	below
Anthony	unavailable	unavailable	31	unavailable	42	201	37
Silver City	unavailable	unavailable	unavailable	unavailable	unavailable	533	
Deming	unavailable	unavailable	unavailable	unavailable	unavailable	320	
Lordsburg	unavailable	unavailable	unavailable	unavailable	unavailable	23	
T or C	unavailable	unavailable	2	unavailable	3	23	2
Las Cruces	unavailable	unavailable	72	unavailable	84	1613	76
Ruidoso	unavailable	unavailable	18	unavailable	17	263	13
Mescalero	unavailable	unavailable	25	unavailable	23	35	20
Alamogordo	unavailable	unavailable	17	unavailable	20	715	18
Total:	2915	85	165	4154	189	3726	166

HUMAN SERVICES DEPARTMENT

Open Skies							
Open Skies							
Bernalillo	unavailable	unavailable	33	unavailable	22	686	29
Valencia	unavailable	unavailable	4	unavailable	7	171	8
Rio Rancho	unavailable	unavailable	7	unavailable	6	137	3
Cibola	unavailable	unavailable	15	unavailable	9	55	7
Total:	1283	142	59	1220	44	1049	47
Turquoise Health							
Turquoise							
Carlsbad	unavailable	unavailable	6	1100	3	unavailable	5
Artesia	unavailable	unavailable	4	unavailable	2	unavailable	2
Roswell	unavailable	unavailable	8	800	6	unavailable	6
Turquoise:	noted above	noted above	n/a	650	n/a	noted above	n/a
Roy	n/a	n/a	n/a	n/a	n/a	n/a	2
Clovis	unavailable	unavailable	26	unavailable	16	unavailable	17
Portales	unavailable	unavailable	11	unavailable	9	unavailable	5
Tucumcari	unavailable	unavailable	13	unavailable	8	unavailable	11
Ft. Sumner	unavailable	unavailable	0	unavailable	0	unavailable	0
Total:	1368	28	68	2550	44	3016	48
Valle del Sol							
Valle del Sol							
Raton	unavailable	unavailable	38	unavailable	29	48	29
Espanola	unavailable	unavailable	64	unavailable	71	154	66
Taos	unavailable	unavailable	35	unavailable	47	107	40
Total:	291	190	137	0	147	309	135
Valle del Sol	862	0	n/a	1027		1734	
Total:	1153	n/a	n/a	1326		2043	135
Grand Totals:	**10318**	**1027**	**668**	**12004**	**699**	**12817**	**694**

Centennial Care Demonstration – 1115 Quarterly Report
Demonstration Year 1: 1/1/14 - 12/31/14
Reporting Period: January 1, 2014 – March 31, 2014
DLTSS Comments: June 20, 2014

1. **Provider Network (p. 7)** – The state reported that three of the four MCOs met contract standards for PCP-to-member ratios. Please identify which MCO did not meet contract standards, what the PCP-to-member ratio was for the reporting period, and the corrective action being taken, and expected results for the next reporting period.

2. **Enrollment Counts (p. 12)** – Please explain the primary factor(s) driving disenrollment in the first quarter. Also please explain why disenrollment is disproportionately higher for the TANF and related population than the other demonstration populations.

3. **Health Plan Compliance and Financial Performance (p. 24)** – The state reported some categories of providers are having difficulty billing and MCOs are having difficulty in paying some categories of providers/services. Please describe remediation for these two issues. Please specify whether the billing and/or payment problems are creating financial hardship for providers and/or whether the access to needed services has been negatively impacted as a result. If yes for either, please describe how this is being addressed by the state.

4. **Quality Assurance/Monitoring Activity:**
   a. Care Coordination (pp. 26-27) – The state reported that MCOs are having difficulties reaching members resulting in delays conducting comprehensive needs assessments and/or renewing expired or soon to expire level of care assessments. HSD will be convening the MCOs to develop a plan for finding unreachable members. Please note progress on this issue in the next quarterly report and describe the long-term strategy for tracking hard to reach Centennial Care members, particularly for Molina and PHP for which more than half all members were reported as unreachable.

   b. Service Plans (p. 30) – The HSD/MAD Quality Bureau approved two MCO requests for reductions due to participants no longer meeting the minimum functional eligibility requirements for receiving long term services and supports. Please describe how the participants were informed of their Fair Hearing Rights and how a transition to other available supports will be facilitated by the MCO and/or State if not appealed by the affected participants or if an appeal is denied.

5. **Home and Community Based Services:**
   a. Independent Consumer Support System (p. 32) –
      i. For the ADRC Call Profiler Report, please provide narrative on the nature of the calls received, particularly the HCBS calls (87% of all calls). For future reports, please include data on how many calls were resolved.
      ii. Please describe the state's contingency plan to provide independent support in lieu of any non-MCO, non-state organizations, proposed as part of the ICSS, that choose not to participant in the ICSS.

b. Critical Incidents (p.34-35) –

- **i.** *Abuse, Neglect and Exploitation* - Please report on the incidence of abuse (227 cases), neglect (169 cases), exploitation (81), and elopement/missing (17) by allegation, substantiated incident, whether reported in amount of time required by the state, whether investigations were started and completed according to state requirements, and what sanctions/corrective actions were taken. How will the state be using ANE data to inform system improvements and prevent future harm to participants?
- **ii.** *Deaths* – The state reported 58 unexpected deaths, 3 homicides, and 1 suicide. Please explain the nature of the 3 homicides and 1 suicide and whether any occurred under the care of a provider, including but not limited to community benefit service providers. How will the state be using decedent data to inform system improvements and prevent future harm to participants? Please clarify if investigations were started and completed according to state requirements, and what, if applicable, sanctions/corrective actions were taken to prevent future occurrences.
- **iii.** Please specify the percentage of abuse/neglect incidents that were only noted in the self-directed member's care plan but not referred to the proper agency for investigation and follow up. What compliance actions were taken by the state? How were MCOs reminded of their responsibility to properly report all critical incidents? What steps has the state taken to ensure health and welfare for alleged victims whose cases were not properly reported?
- **iv.** *Mi Via-NF waiver transitions* – For Mi Via participants transitioning into Centennial Care, please specify how many receiving waiver assisted living services will lose access to self-directed services previously received under Mi Via and what those self-directed waiver services are if assisted living is chosen over access to self-direction. Please clarify whether the state is limiting choice of community benefit services to either all agency-based services or all self-directed services as implied by the state's report on Mi Via-NF waiver transitions, or whether individuals eligible for the community benefit may choose the self-direction or agency-based benefit by availability for each service as delineated in STC 30.

6. Action Plans for Addressing Any Issues Identified (pp.38-40)

- **a.** Please clarify the difference between "unreachable members" reported generally for all MCOs and "unable to contact" reported specifically for Molina.
- **b.** Please describe the systems issues and barriers identified and mitigated by BCBS for Community Benefit Services Plan Monitoring. If detailed in the narrative, please cross-reference.
- **c.** Molina is reported to have a high number of expired NF LOCs. This was a past problem for Molina with the CoLTS waiver that the state addressed with Molina prior to the implementation of Centennial Care. Is this issue particular to Molina under Centennial Care or more related to the difficulty reaching members? If related to the broader issue of difficulty contacting members, please explain if and what action plans are necessary for other MCOs as well.

HUMAN SERVICES
DEPARTMENT

Susana Martinez, Governor
Sidonie Squier, Secretary
Julie B. Weinberg, Director

August 28, 2014

Paul J. Boben
Centers for Medicare and Medicaid Services
U.S. Department of Health & Human Services
7500 Security Boulevard
Room: S2-03-18
Mail Stop: S2-01-16
Baltimore, Maryland 21207

RE: New Mexico Centennial Care
Section 1115 Waiver Demonstration- 11-W-00285/6

Dear Paul:

The Section 1115 Waiver Demonstration Program, Quarter 2 Report, for the reporting period, April 1, 2014 through June 30, 2014, for the New Mexico Centennial Care program initiative, 11-W-00285/6, is submitted with this correspondence for your review and approval.

Our State is encouraged with the continued progress evidenced through the implementation of the Centennial Care Program. New Mexico Medicaid recipients are actively engaged in accessing the fully integrated health care delivery system for physical health, behavioral health and long-term care services, afforded by Centennial Care. Continued strides are also being made to ensure that the benefits of care coordination are supporting the needs of individuals and families and in all efforts for improving health outcomes. The Centennial Care Rewards program is another highlighted benefit worth mentioning this quarter in successfully involving recipients through well-received incentives for preventive health care.

It is hoped that this quarterly report provides you with useful and detailed information on the on-going progress of the Centennial Care waiver program. Should you have any questions, please contact Ellen Costilla at (505) 827-3180 or Ellen.Costilla@state.nm.us.

Thank you for your assistance and partnership with our state's administration of the NM Centennial Care 1115 Demonstration Waiver Program.

Sincerely,

[redacted]

Julie B. Weinberg
Director

Enclosure(s)
Cc: Sidonie Squier, Secretary, NM Human Services Department
Bill Brooks, Associate Regional Administrator, CMS Region VI
Stacey Shuman, AR and NM State Lead, CMS Region VI
Teresa Jackson, CMS Region VI Finance Lead
Nancy Smith-Leslie, Deputy Director, Medical Assistance Division, NM HSD

ATTACHMENT A

New Mexico Budget Neutrality Monitoring Spreadsheet

DY 1

Start Date: 01/01/2014

End Date: 12/31/2014

Quarter 2

Start Date:4/01/2014

End Date: 6/30/2014

MEG01 TANF & Related	DY 01	DY1 QTR 1 - Actuals [2]	DY1 QTR 2 - Actuals [2]	DY1 YTD - Actuals
MMs [1]	4,727,584	1,096,908	1,101,074	2,197,982
PMPM	$ 385.80	$ 297.56	$ 266.77	$ 282.14
Dollars [2]	$ 1,823,911,159	$ 326,397,467	$ 293,731,365	$ 620,128,832

MEG02 SSI & Related - Medicaid Only	DY 01	DY1 QTR 1 - Actuals	DY1 QTR 2 - Actuals	DY1 YTD - Actuals
MMs	508,700	122,859	122,631	245,490
PMPM	$ 1,763.90	$ 1,507.80	$ 1,462.72	$ 1,485.28
Dollars	$ 897,298,062	$ 185,246,753	$ 179,374,335	$ 364,621,088

MEG03 SSI & Related - Dual Eligible	DY 01	DY1 QTR 1 - Actuals	DY1 QTR 2 - Actuals	DY1 YTD - Actuals
MMs	373,823	104,627	104,563	209,190
PMPM	$ 1,780.77	$ 1,243.96	$ 1,224.00	$ 1,233.98
Dollars	$ 665,692,378	$ 130,151,508	$ 127,985,356	$ 258,136,864

MEG04 "217 Like" Medicaid Only	DY 01	DY1 QTR 1 - Actuals	DY1 QTR 2 - Actuals	DY1 YTD - Actuals
MMs	5,841	688	606	1,294
PMPM	$ 4,936.92	$ 12,805.72	$ 13,838.35	$ 13,289.32
Dollars	$ 28,834,295	$ 8,810,334	$ 8,386,043	$ 17,196,377

MEG05 "217 Like" Dual Eligible	DY 01	DY1 QTR 1 - Actuals	DY1 QTR 2 - Actuals	DY1 YTD - Actuals
MMs	27,935	6,748	6,721	13,469
PMPM	$ 1,776.90	$ 3,357.26	$ 3,287.63	$ 3,322.51
Dollars	$ 49,637,569	$ 22,654,788	$ 22,096,147	$ 44,750,935

MEG06 Medicaid Expansion	DY 01	DY1 QTR 1 - Actuals	DY1 QTR 2 - Actuals	DY1 YTD - Actuals
MMs	1,632,968	337,434	444,261	781,695
PMPM	$ 577.87	$ 496.74	$ 458.80	$ 475.18
Dollars	$ 943,638,928	$ 167,615,557	$ 203,827,412	$ 371,442,969

Uncompensated Care Pool	DY 01	DY1 QTR 1 - Actuals	DY1 QTR 2 - Actuals
Total Allotment	$ 68,889,323	$ -	$ 6,539,824

Notes:

1.) Member months as reported in the Centennial Care Section 1115 Quarterly Report, Section XI. First quarter, Jan - March 2014 member months reflect revised counts.

2.) Expenditures as reported on the CMS-64 for the June Quarter of FFY14 less IHS payments. Expenditures are classified by DOS in the respective quarter.

EXAMPLE 1
Electronic Visit Verification Status Update
June 18, 2014

Issue	BCBS	UHC	Molina	PHP
Please verify that all MCOs have all authorizations entered in their system and that all personal care providers, specifically the test/pilot providers, have all the authorizations for their membership.	BCBS is in the process of verifying that all authorizations for the four pilot providers are in our system. For any gaps identified, authorizations will be entered and an authorization letter will be mailed to the provider no later than 06/27/14. The verification of all authorizations for the four pilot providers will be completed by 6/27/14.	All UHC authorizations have been completed for the four agencies participating in the pilot. In addition, authorizations have been faxed to the agencies for their record.	Authorizations from Molina will be available in the AuthentiCare system today by 2pm MT. The pilot providers have received hard copies also.	PHP is currently reviewing each authorization for the four pilot providers. If a hard copy of the authorization has not previously been sent to the provider, one is being generated and sent. Any authorizations that may appear inaccurate are being corrected and the provider is being contacted to ensure that the corrections align with services being provided. In addition, PHP has received lists of members from the pilot providers to cross check and ensure that member information is consistent. It is anticipated that this review process will be completed by the middle to end of next week, no later than June 27th.

	The synthesis of this information helps create a market based MAC price for generic items included on the MAC list. These sources are monitored and updates are used to help manage the market fluctuations of pricing on the MAC list. The MAC lists are reviewed on a monthly basis.
Molina	Maximum Allowable Cost: Caremark's Industry Analysis monitors the MAC for prescription drugs and updates drug pricing appropriately. Caremark's Industry Analysis monitors pricing inquiries from pharmacies and changes within the pharmaceutical industry which may trigger the need for a pricing review. Caremark considers several factors including bioequivalence, number of vendors in the marketplace, and availability of product. Claims volume also is taken into consideration. The MAC unit price is established by applying various formulas after reviewing information from several sources. Pricing sources may include Medi-Span (or any other similar nationally recognized reference), wholesalers, MAC list published by CMS, and retail pharmacies. Caremark continuously monitors MAC prices, and MAC prices are adjusted based on marketplace trends and dynamics, and to meet contract commitments. Caremark complies with applicable state laws regulating MAC management.

What is the plan and timeline for implementing a Spanish language option going forward?	The IVR has been programmed in Spanish and English. As indicated in the provider training sessions, the provider is to designate the worker's language preference (English or Spanish) on the worker spreadsheet. When Spanish is the preferred language and the worker calls the IVR, after they enter their worker ID, they will hear the prompts in Spanish. This is currently in the test environment, and will be in production by the end of the day, tomorrow.	Authenticare made a change to the IVR flow to reduce overall time. Instead of having the prompt to select language, we pull the setting from the worker record itself. If the worker record is set to Spanish, after they enter the worker ID, the IVR automatically plays in that language from then on.	The IVR has been programmed in Spanish and English. As indicated in the provider training sessions, the provider is to designate the worker's language preference (English or Spanish) on the worker spreadsheet. When Spanish is the preferred language and the worker calls the IVR, after they enter their worker ID, they will hear the prompts in Spanish. This is currently in the test will be production by the end of the day, tomorrow.	The four MCOs are working on the Spanish speaking capability and prompts- we have contacted FirstData to provide additional information. The IVR has been programmed in Spanish and English. As indicated in the provider training sessions, the provider is to designate the worker's language preference (English or Spanish) on the worker spreadsheet. When Spanish is the

	After review, the drug pricing is loaded into the Caremark adjudication system and quality checks are performed to guarantee accuracy. Drug File Updates: The Caremark Drug File Administration team reviews reports that summarize the results of daily, weekly, and monthly data loads to the Enterprise Drug File system based on files provided by Medispan and First Databank (FDB). The purpose of the review is to ensure the integrity of data that is being newly added to or updated in the system. The Drug File contains drug information that is available in the industry, which includes, but not limited to; therapeutic classifications, product registrations, packaging information, manufacturer identification, and current unit costs. Upon loading of the data, review is performed and if any discrepancies arise, mitigating actions are taken. A secondary review of all reports and related data changes is performed to ensure quality control. Reports are initialed by both primary and secondary reviewers to serve as evidence that proper process controls are being applied.
PHP	Pricing is updated via the Medispan loads that are performed on a daily and weekly basis by the PBM; these files come directly from Medispan. These files update the pricing fields (AWP) information.