Centennial Care Waiver Demonstration

Section 1115 Annual Report
Demonstration Year: 5 (1/1/2018 – 12/31/2018)

April 1, 2019

New Mexico Human Services Department

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SECTION I: INTRODUCTION

On July 12, 2013, the Centers for Medicare and Medicaid Services (CMS) approved New Mexico's Centennial Care Program 1115 Research and Demonstration Waiver. The approval of the waiver is effective from January 1, 2014 through December 31, 2018.

Launched on January 1, 2014, Centennial Care places New Mexico among the leading states in the design and delivery of a modern, efficient Medicaid program. Approximately 670,000 members are currently enrolled in the program.

The goals of the Centennial Care Program at implementation included:

- Assuring that Medicaid recipients in the program receive the right amount of care at the right time and in the most effective settings;
- Ensuring that the care being purchased by the program is measured in terms of its quality and not its quantity;
- Slowing the growth rate of costs or "bending the cost curve" over time without cutting services, changing eligibility or reducing provider rates; and
- Streamlining and modernizing the program.

In the development of a modernized Medicaid program, New Mexico articulated four (4) guiding principles:

1. Developing a comprehensive service delivery system that provides a full array of benefits and services offered through the State's Medicaid program;
2. Encouraging more personal responsibility so that recipients become more active participants in their own health and more efficient users of the health care system;
3. Increasing the emphasis on payment reforms that pay for performance rather than payment for the quantity of services delivered; and
4. Simplifying administration of the program for the State, for providers and for recipients where possible.

These guiding principles continue to steer New Mexico's Medicaid modernization efforts and serve as the foundation for the 1115 demonstration waiver.

The four Managed Care Organizations (MCOs) contracted with New Mexico to deliver care are:

- Blue Cross Blue Shield of New Mexico (BCBS)
- Molina Healthcare of New Mexico (MHC)
- Presbyterian Health Plan (PHP)
- UnitedHealthcare (UHC)

SECTION II: SUMMARY OF QUARTERLY REPORT OPERATIONAL ISSUES

Annual Budget Neutrality Monitoring Spreadsheet

The annual budget neutrality monitoring spreadsheet for demonstration year four (DY5) is included in this report as Attachment A.

Health Care Delivery System Update Benefits

Planning for Centennial Care 2.0 new initiatives and services occurred during the demonstration year; however, these would not be effective until 2019. There were no new covered services added during demonstration year 5 (DY5). MCOs may, and do, offer Value Added Services (VAS) to their members to supplement Covered Services. These are reviewed and approved by HSD annually. VASs vary by MCO and are described, along with any requirements or exclusions, in Attachment B, 2018 Value Added Services.

New Mexico Consumer, Family/Caregiver and Youth Satisfaction Project

The New Mexico Consumer, Family/Caregiver and Youth Satisfaction Project (CFYP) is a yearly effort to survey the satisfaction of New Mexico Adult individuals, Family/Caregivers and Youth receiving state funded mental health and substance abuse treatment and support services.

The CFYP surveys serve two purposes:

- To inform a quality improvement process to strengthen services in New Mexico; and,
- To fulfill federally mandated data reporting requirements.

Adults, family members and youth answer the survey through face-to-face or telephone interviews. Provider locations for face-to-face interviews are pre-selected each year. Telephone interviews were obtained from a pool of randomly-selected individuals or families who received behavioral health services from New Mexico Medicaid or Behavioral Health programs. For more information and findings from DY5, please see Attachment C: 2018 NM Consumer and Family Executive Summary.

Enrollment

Centennial Care enrollment indicates a decrease in enrollment for TANF, SSI and Related Dual with the Expansion population remaining stable. The majority of Centennial Care members are enrolled in TANF and Related with Group VIII being the next largest group as reflected in the table below. The following table outlines all enrollment activity under the demonstration. The enrollment counts include unique enrollees, 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. Since members change eligibility and thus MEGs during the year, the only way to give an unduplicated count for the quarter and YTD is to look at the last month a client was in the MEG within the period. For that reason, the unduplicated total for YTD could be less than a prior quarter.

Disenrollment

Centennial Care disenrollment indicates a decrease in disenrollment in all populations. The definition of disenrollment is when a member was enrolled in Centennial Care at some point in the prior quarter and disenrolled at some point during that same quarter or in the reporting quarter and did not re-enroll at any point in the reporting quarter. Members who switch MEGs are not counted as disenrolled. The majority of disenrollment are attributed to loss of eligibility and death. HSD continues to monitor disenrollment and any potential issues. Validation checks are run periodically to identify any potential gaps in enrollment. Any issues that are identified or reported are researched and addressed.

Complaints and Grievances

In DY5 a total of 3,618 member grievances were reported by Centennial Care members. This demonstrates a decrease when compared to member grievances received in DY4 (4,081), DY3 (3,787), DY2 (4,385) and an increase when compared to DY1 (2,668). The number of total member grievances filed by BCBS for Q3 has increased since the publishing of the DY5Q3 report. This was due to unreported member grievances not reflected in the MCOs quarterly data submission. HSD has revised DY5 Q3 totals to reflect this.

Non-Emergency Ground Transportation constitutes the largest number of grievances reported. The total grievances received was 1,827 (50.49 percent). This demonstrates a slight increase when compared to DY4 (1,519), DY3 (919), DY2 (1,241), and DY1 (1,006). Transportation Grievances in Section II of this report provides the MCOs efforts to address transportation grievances under the guidance of HSD.

The second top member grievance reported in DY5 was related to Other Specialties with a total of 285 (7.88 percent) member grievances reported. This demonstrates a decrease when compared to DY4 (301), DY3 (514), DY2 (301), and an increase from DY1(134). The member grievances filed by PHP for Q2 has increased since the publishing of the DY5Q2 report. This was due to unreported grievances categorized as "Other Specialties" not reflected in the MCOs quarterly data submission. HSD has revised DY5 Q2 totals to reflect this.

There were 1,506 (41.63 percent) variable grievances reported in DY5. Of those, each MCO reported unique grievances that do not provide data to establish a trend. HSD is monitoring these grievances to identify specific trends.

Table 1 – MCO Grievances DY5

MCO Grievances DY5										
MCO	**BCBS**		**MHC**		**PHP**		**UHC**		**Total**	
Member Grievances	#	%	#	%	#	%	#	%	#	%
Number of Member Grievances	1,026	28.36%	657	18.16%	1,115	30.82%	820	22.66%	**3,618**	100.00%
Top Member Grievances										
Transportation Ground Non-Emergency	697	19.26%	187	5.17%	568	15.70%	375	10.36%	**1,827**	50.49%
Other Specialties	84	2.32%	0	0.00%	50	1.38%	151	4.18%	**285**	7.88%
Variable Grievances	245	6.77%	470	12.99%	497	13.74%	294	8.13%	**1,506**	41.63%

Member Appeals

In DY5, a total of 3,330 member appeals were reported by Centennial Care members. This demonstrates a decrease when compared to DY4 (3,932), DY3 (5,104), DY2 (5,435). Of those 3,330 member appeals, 2,928 (87.93 percent) were standard member appeals and 402 (12.07 percent) were expedited member appeals. All MCOs processed acknowledgement notices in a timely manner.

Denial or limited authorization of a requested service constitutes the largest number of appeals reported. The total denied or limited service authorizations appeals received was 2,815 (84.53 percent). This demonstrates a decrease when compared to DY4 (3,296), DY3 (3,304) and DY2 (4,099).

Reduction of a previously authorized service was the second top member appeal code with a total of 207 (6.22 percent) member appeals reported. This demonstrates a decrease when compared to DY4 (332), DY3 (511), and DY2 (756). The total number of member appeals filed by PHP and UHC for Q2 has increased since the publishing of the DY5Q2 report. This was due to unreported appeals related to "Reduction of a previously authorized service" not reflected in the MCOs' quarterly data submission. HSD has revised DY5 Q2 totals to reflect this.

There were 308 (9.25 percent) variable appeals reported in DY5. Of those, each MCO reported unique appeals during each quarter that do not provide enough information to establish a trend. All MCOs have complied with the policies and procedures regarding members' exhaustion of the Grievance and Appeal System prior to requesting a State Fair Hearing.

Table 2 – MCO Appeals DY5

MCO Appeals DY5										
MCO	**BCBS**		**MHC**		**PHP**		**UHC**		**Total**	
Member Appeals	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	%
Number of Standard Member Appeals	469	14.08%	603	18.11%	1,493	44.84%	363	10.90%	**2,928**	87.93%
Number of Expedited Member Appeals	260	7.81%	30	0.90%	15	0.45%	97	2.91%	**402**	12.07%
Total	729	21.90%	633	19.00%	1,508	45.29%	460	13.81%	**3,330**	100%
Top Member Appeals										
Denial or limited authorization of a requested service	610	18.31%	530	15.92%	1,347	40.45%	328	9.85%	**2,815**	84.53%
Reduction of a previously authorized service	21	0.63%	112	3.36%	50	1.50%	24	0.72%	**207**	6.22%
Variable Appeals	98	2.94%	-9	-0.27%	111	3.33%	108	3.24%	**308**	9.25%

Access

Throughout this report, unless otherwise noted, the most current quarterly data is available through September 2018 which is the third quarter of calendar year 2018.

To ensure the MCOs' compliance in maintaining member access and an adequate provider network, HSD monitors new and terminated providers, member to provider ratios and GeoAccess reports. All MCOs were far below the primary care provider (PCP)-to- member contractual required ratio of 1:2000 throughout DY5. From December 2017 to September 2018 ratios ranged from 1:26 to 1:97 (71). Please see Table 3: PCP-to-Member Ratios by MCO.

In September 2018, PHP gained approximately 70,000 members from UHC. An increase in ratio is a reasonable reflection of members transitioning into a different provider network. Monthly data reflects a stabilization of PHP network and only at a slightly higher ratio.

Table 3 – PCP-to Member Ratios by MCO

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep
BCBS	1:34	1:36	1:37	1:35	1:36	1:37	1:32	1:33	1:35
MHC	1:91	1:91	1:90	1:87	1:85	1:83	1:83	1:82	1:81
PHP	1:74	1:74	1:74	1:84	1:82	1:74	1:73	1:72	1:97
UHC	1:30	1:29	1:28	1:29	1:29	1:28	1:26	1:26	ND

Source: [MCO] PCP Report #53 Q1, Q2, & Q3 Calendar Year 2018

Geographic access requirements for dentists, hospitals, pharmacies, primary care physicians, and most specialty providers were met in urban, rural and frontier counties. A shortage of providers continues in specialty areas including dermatology, endocrinology, neurology, neurosurgeons, rheumatology, and urology. In areas that MCOs do not meet access criteria, they utilize non-emergency transportation, telemedicine, and single case agreements to ensure that the members who require medically necessary services receive them. Please see Attachment D– GeoAccess PH Summary.

Behavioral Health Geo Access

Throughout DY5, access standards continue to be met, statewide, for behavioral health (BH) services with few exceptions and little change in urban, rural and frontier areas through Core Service 8 Agencies (CSA), Community Mental Health Centers (CMHC), Outpatient provider agencies, psychiatrists, psychologists, Suboxone certified MDs, and other licensed independent behavioral health practitioners.

Rural and frontier access standards remain unmet with limited exceptions, for the following: Freestanding Psychiatric Hospitals, General Hospitals with psychiatric units and partial hospital programs. Treatment Foster Care I & II, Behavioral Management Services, Day Treatment Services, Intensive Outpatient Services, Methadone Clinics Assertive Community Treatment (ACT) and Multi-Systemic Therapy (MST). Rural access standards for Behavioral Health clinics are not met by the majority of MCOs.

With a few exceptions, none of the urban, rural and frontier access standards were met for non-accredited residential treatment programs, Indian Health Services and Tribal 638s providing BH, Day Treatment Services, and Rural Healthcare Clinics providing BH services.

HSD continues to be aware of the BH services that do not meet the standards due to provider shortages in New Mexico. MCOs continue to work to strengthen their relationships with the existing BH providers in their networks meeting routinely with them and with the State. Continued efforts to increase accessibility include expansion of telemedicine, maintaining open panels, and reimbursement for extended hours.

The Interdepartmental Council (IDC), made up of Children, Youth, and Families Department (CYFD) and HSD, has been processing applications and conducting site visits to continue expansion of approved Intensive Outpatient Programs (IOP) statewide. CareLink New Mexico (CLNM) increased the number of Health Homes leading to increased accessibility for Medicaid beneficiaries with serious mental illness (SMI) for adults and severe emotional disturbance (SED) for children and adolescents throughout DY5 CY18.

MCOs continued to maintain and build access to BH services with the current BH networks by increasing routine collaboration with the New Mexico Behavioral Health Provider Association (NMBHPA) while continually striving to build accessibility through efforts to provide innovative service delivery to their members by utilizing care coordinators, family and peer supports and Community Health Workers (CHWs). MCOs support their available network in ways such as having a Behavioral Health provider service representative routinely visit providers to validate practice information, respond to claims and other issues. MCOs are looking at value-based purchasing to increase access with appointment availability and utilizing High Fidelity Wrap around services to meet the needs of members. MCO Network contracting teams monitor the out of network providers from the single case agreement files to recruit additional practitioners to

participate in the Behavioral network. Ongoing network assessments by MCOs have identified recruitment opportunities with out of state border facilities for Inpatient BH services. Also notable is that MCOs continue to frequently be contracted with the entire available network for some services such as all approved Inpatient Psychiatric Hospitals and General BH Acute Hospitals in New Mexico although access standards are not met. The MCOs utilize additional border resources to provide members with access to services. Please see Attachment E – GeoAccess BH Summary.

Secret Shopper Survey

Medicaid-enrolled providers with the State of New Mexico are potentially able to contract with any, or all, of the Centennial Care MCOs, all of which provide services to members statewide. MCOs are now reporting Secret Shopper Surveys with Primary Care Providers (PCPs) semi-annually to monitor appointment timeliness in all regions across the state for routine and urgent visits. Due to variations in report methodologies across MCOs, HSD will work with MCOs to standardize a format that will allow for MCO comparisons across provider networks and will consider only the Medicaid member lines of business.

Telemedicine

All Managed Care Organizations (MCOs) promoted the use of technology to provide increased member access to telemedicine services in New Mexico. Technical assistance for telemedicine services, primary interventions and education for telemedicine coding was a focus area in DY5 for providers interested in providing telemedicine. MCOs provided telemedicine services for both Physical Health (PH) and Behavioral Health (BH) services, with BH services reported as the majority of telemedicine visits for DY5.

HSD will provide final DY5 data in the upcoming Q1CY19 report due to claims runout. Please see Table 4: Telemedicine 2013 - 2018 for results to date.

Table 4 – Telemedicine 2013 - 2018 Results

	Baseline			1st Year Results			2nd Year Results			3rd Year Results			4th Year Results			5th Year Results thru Q3CY18		
	2013 Behavioral Health	2013 Physical Health	2013 Total	2014 Behavioral Health	2014 Physical Health	2014 Total	2015 Behavioral Health	2015 Physical Health	2015 Total	2016 Behavioral Health	2016 Physical Health	2016 Total	2017 Behavioral Health	2017 Physical Health	2017 Total	2018 Behavioral Health	2018 Physical Health	2018 Total
BCBSNM	19	3	22	1,078	91	1,169	1,213	803	2,016	2,362	2,803	5,165	2,645	2,062	4,707	2,545	1,535	4,080
MHNM	7 *	0	7	1,909	32	1,941	2,132	754	2,886	3,579	98	3,677	4,213	219	4,432	4,154	416	4,579
PHP	2,016	4	2,020	3,006	143	3,149	3,809	134	3,943	5,045	280	5,325	10,119	180	10,299	10,925	120	11,045
UHC	89	22	111	1,046	96	1,142	1,833	236	2,069	1,786	1,000	2,786	4,664	1,944	6,608	3,266	1,544	4,810
TOTAL	2,131	29	2,160	7,039	362	7,401	8,987	1,927	10,914	12,772	4,181	16,953	21,641	4,405	26,046	20,890	3,615	24,514

In 2013, Medicaid behavioral health services were administered by OptumHealth New Mexico.

Source: MCO Delivery System Improvement Performance Target Reports -Q1CY14-Q3CY18.

Provider technical assistance, billing training sessions and education have been key focus areas for increasing the use of telemedicine. MCOs worked with telemedicine specialty services to identify opportunities to improve access and capacity in rural and frontier areas.
Specialty services provided in DY5 included:

- Psychiatry
- Neuropsychology
- Psychotherapy
- Dermatology
- Otolaryngology
- Optometry
- Intensivist
- OB/Gynecology
- Fetal Medicine
- Nephrology
- Pulmonology
- Addiction Medicine

MCOs strove to meet the goal of increasing member utilization by a 15% increase in telemedicine visits over DY4 goals, with outreach made to inform members about the options available for telemedicine, through townhalls and education materials on virtual visit technology and originating site locations.

Transportation

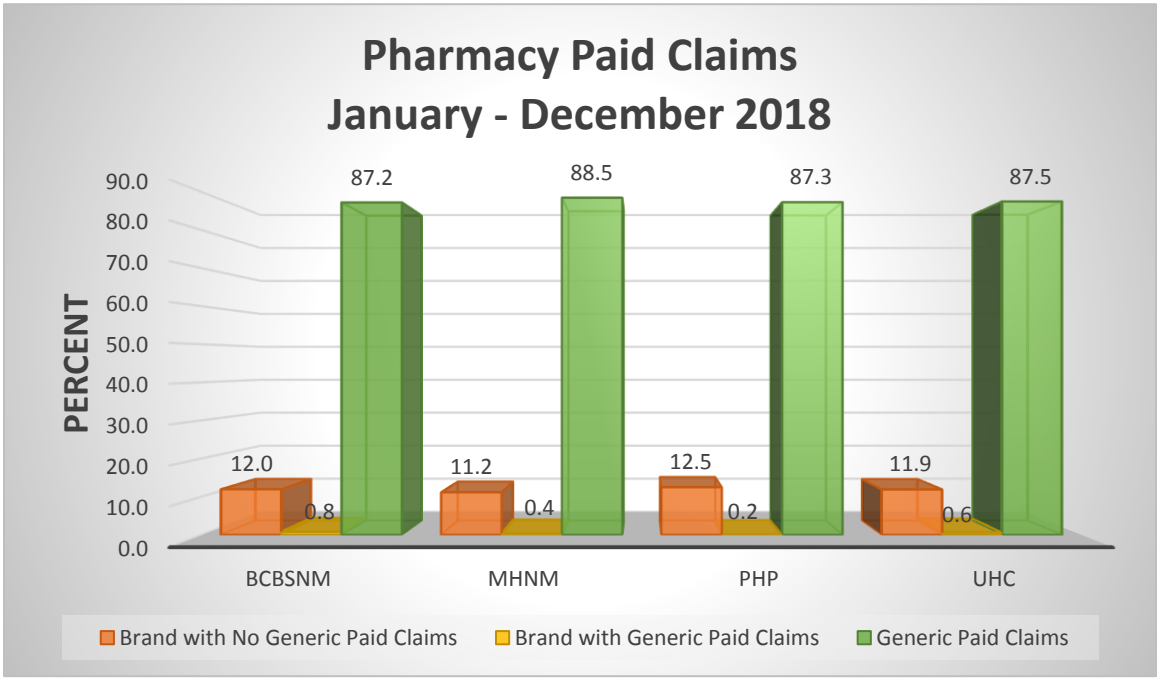
In DY5, all MCOs met geographic access standards for non-emergent ground transportation in urban, rural and frontier areas. Consistent with previous reporting Non-Emergency Medical Transportation (NEMT) grievances have represented the highest percentage of total member grievances in DY5. Please see Complaints and Grievances for additional information.

Pharmacy

HSD monitors the MCOs' utilization of generic medication, brand with generic and brand with no generic. MCOs are required to use generic drugs when available and require medical justification for usage of brand drug use when a generic drug is available. In DY5, HSD identified the following:

- 87.6% average generic drug utilization for all four MCOs;
- 11.9% average brand with no generic available for all MCOs; and
- 0.5% average brand use with a generic drug available for all MCOs.

Table 5 – Pharmacy Paid Claims, January – December 2018



Source: [MCO] Report #44, December 2018

In DY5, HSD continued to work on standardizing pharmacy reporting to ensure a consistent methodology is utilized across all MCOs and will allow for a more thorough analysis of pharmacy services. The revised report will continue to monitor claims data, prior authorizations, and therapeutic classifications as well as add the monitoring of drugs for the treatment of opioid dependence, alcohol and nicotine dependence, utilization of central nervous system (CNS) stimulants in children and adults, HIV/AIDS treatment, and utilization of atypical antipsychotic medications in children.

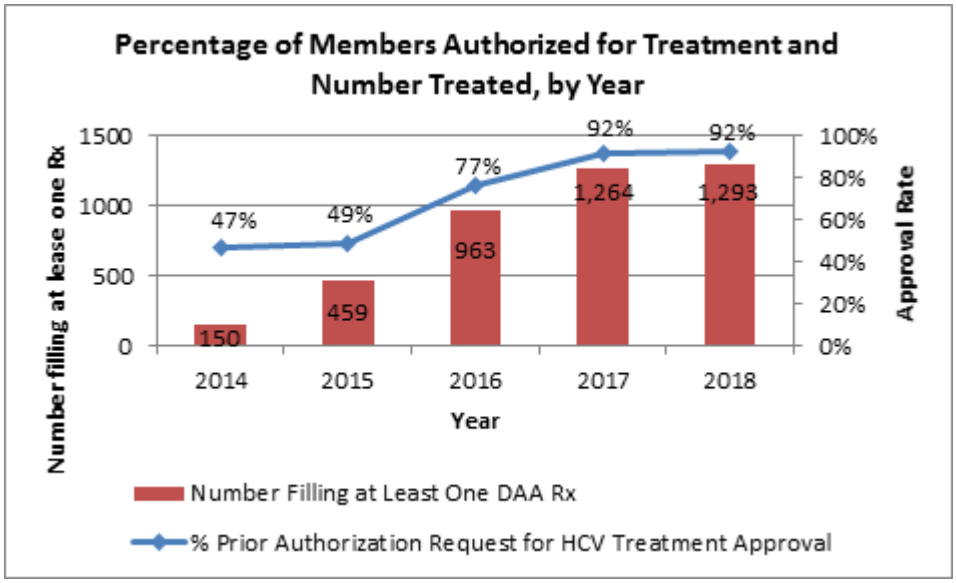
Hepatitis C (HCV)

The DY5 HCV Delivery System Improvement Performance Target (DSIPT) was increased to 80% of their member-month adjusted target in 2018. HSD continued to host quarterly meetings and work with the MCOs to support the HCV treatment delivery system and assure members' access to care. The group addressed issues such as screening, case finding and provider incentive.

MCOs are required to treat all members over the age of 17 with active HCV infection F0, F1, F2, F3, F4, decompensated cirrhosis, and hepatocellular carcinoma. In addition, the MCOs are instructed to develop a provider incentive plan to expand the number of practitioners treating chronic HCV in New Mexico, including incentives to receive training in the treatment of chronic HCV infection and initiating HCV treatments.

HSD reviewed the MCOs' quarterly HCV prior authorization reports and at year-end compared prior authorization approval rates to the number of members filling at least one direct-acting antiviral (DAA) prescription. In 2018 there was a 92% approval rate for treatment, which is the same as 2017's approval rate. Additionally, preliminary analysis of the 2018 encounter data through Q3DY5 shows that there were 1,275 members that filled at least one DAA prescription. HSD is awaiting claims runout and finalized encounter data for DY5. Please see Table 6: Percentage of Members Authorized for Treatment and Number Treated by Year.

Table 6 – Percentage of Members Authorized for Treatment and Number Treated by Year



Community Interveners

In DY5, there were seven Centennial Care members who received the Community Intervener (CI) services as illustrated below. This was an increase as compared to five members in DY4. The MCOs continue to provide education to their Care Coordinators to assist in identifying members that meet the criteria for the CI service.

Table 7 – Consumers and Community Intervener Utilization

MCO	# of Members Receiving CI	Total # of CI Hours Provided	Claims paid
BCBS	1	71	$465
MHC	0	0	$0
PHP	3	224	$5,659
UHC	3	607	$3,894
Total	**7**	**902**	**$10,018**

Source: [MCO] Utilization Management Report #41, Q4CY18

Long-Term Services and Supports

Centennial Care 2.0 Readiness Activities

In DY 5, HSD turned its attention to ensuring a smooth transition to Centennial Care 2.0 for LTC members transitioning from one MCO to another. In October 2019, HSD began individual LTSS weekly meetings with all of the MCOs, including the exiting and incoming plans. The topics that were discussed and monitored by HSD included:

- Environmental modifications in progress during the transition;
- EVV implementation for the incoming MCO, Western Sky Community Care (WSCC);
- Transition of LTSS service authorizations, with a focus on personal care services (PCS);
- Transition of care coordination files (HRA, CNA, etc) for transitioning LTSS members;
- Transition of Nursing Facility Level of Care (NF LOC) determinations through collaboration with the MCOs' UM Departments;
- LTSS and care coordination training and policy clarification as needed for WSCC;
- System interfaces;
- LTSS provider contracting by the MCOs, including NF contracting; and
- Implementation of Continuous NF LOC and other CC 2.0 new LTSS initiatives.

In DY 5, HSD provided extensive LTSS training to WSCC to ensure that they implemented CC 2.0 correctly. HSD shared these updated training presentations with the continuing MCOs as well. HSD also attended and observed WSCC's LTSS training sessions for their new care coordinators.

Home and Community-Based Services Final Rule

In January 2017, HSD received initial CMS approval of its Statewide Transition plan. In late 2017, HSD in partnership with the Aging and Long-Term Services Department (ALTSD) conducted on-site provider reviews and participant surveys as required by CMS. HSD continues to update its Final Settings Rule milestones, as NM moves towards full compliance with the Rule.

Electronic Visit Verification (EVV)

The full implementation of an EVV system beginning in November of 2016 has proven successful, even in New Mexico's frontier and no-tech zone areas due to the seven day store and forward capability in the system. In DY5, MCOs and their subcontractors continued to provide assistance to PCS agencies with the EVV system, connectivity issues, and billing as needed. HSD continues to monitor the MCOs' EVV implementation through regular reporting.

HSD and the MCOs partner with the New Mexico Association for Home Health and Hospice Care (NMAHHC) to provide information on the EVV system and discuss provider concerns at each of the Association's quarterly conferences. Providers appreciate this collaboration, and system improvements have been implemented based on their feedback.

In DY 5, HSD, in collaboration with MCOs and their vendors, began planning for the implementation of EVV for Self-Directed Community Benefit PCS.

Centennial Rewards

The Centennial Rewards program provides incentives to members for engaging in and completing healthy activities and behaviors as described below.

- **Asthma Management** to reward refills of asthma controller medications for children;
- **Bone Density Testing** to reward women age 65 or older who complete a bone density test during the year.
- **Diabetes Management** to reward members who complete tests and exams to better manage their diabetes;
- **Healthy Smiles** to reward annual dental visits for adults and children;
- **Healthy Pregnancy** to reward members who join their MCO's prenatal program;
- **Step-Up Challenge** to reward completion of a 3-week or 9-week walking challenge; and
- **Schizophrenia and/or Bipolar Disorder Management** to reward members who refill their medications.

Members who complete these activities can earn credits, which can then be redeemed for items in the Centennial Rewards catalog. All Centennial Care members are eligible for Centennial Rewards. To date, 714,199 distinct members, or 70.7 percent of all Centennial Care enrollees, have earned at least one incentive or reward. F i v e full years of data reflect members have earned points totaling a value of $61.9 million. The table below shows the healthy behaviors that have been rewarded and each activity's value in dollars. It includes the maximum dollar value available for each activity and the total dollars earned.

Table 8 – Healthy Behaviors Rewarded

Reward Activities	Reward Value in Points, by Activity	Maximum Reward Dollar Value	Total Rewards Earned (Dollar Value)
Asthma Management	6	$6	$1,399,155
Bipolar Disorder Management	6	$6	$1,712,280
Bone Density Testing	3	$3	$82,530
Healthy Smiles Adults	2	$2	$13,401,425
Healthy Smiles Children	3	$3	$29,393,770
Diabetes Management	6	$6	$7,202,880
Healthy Pregnancy	1000	$100	$1,880,300
Schizophrenia Management	6	$6	$949,905
Step-Up Challenge	5	$5	$720,275
Health Risk Assessment*	1	$1	$4,396,090
Other (Appeals and Adjustments)	N/A	N/A	$792,338
Totals			**$61,930,948**

***HRA completion was discontinued as a rewardable activity at the end of CY2016**

The Step-Up Challenge remains the most popular activity offered through the Centennial Rewards program, with more than 90,000 members having registered for the Challenge and logged their steps to date. Data shows that participants in the Step-Up Challenge continue to show lower costs and improved quality across multiple indicators.

Overall, New Mexico's Centennial Rewards program has achieved over $120 million in savings since 2014, and participants across all conditions have shown 20 percent to 50 percent higher compliance with HEDIS-related scores. Participant costs were between 2.2 percent and 27 percent lower across all conditions, with reduced inpatient admissions and lower costs per admission among participants being the predominant driver behind cost savings. Notably, rates of behavioral health medication adherence exceed 80 percent among Rewards participants. The state has also seen overall increases in preventive screenings, high value PCP visits, and pharmacy refills among participants.

Participation in the Centennial Rewards program remains remarkably strong and is likely the highest participation rate for a program of its kind in the nation. Since the beginning of the program, there have been over one million visits to the Centennial Rewards member portal. Most importantly, member satisfaction has remained exceptionally high, with 96 percent of members reporting satisfaction with the Centennial Rewards program, and 97 percent reporting that the program has led them to making healthier choices.

Other Operational Issues

Contract Amendments

There was one amendment to the Medicaid Managed Care Services Agreement in DY5. Contract Amendment #8 can be found on the HSD website at http://www.hsd.state.nm.us/LookingForInformation/medical-assistance-division.aspx.

Adverse Incidents

HSD continues to meet quarterly with the Critical Incident (CI) workgroup in an effort to provide technical assistance to the MCOs. The Critical Incident Report (CIR) trainings are held annually to ensure providers have an understanding of reporting requirements. The workgroup supports the Behavioral Health Services Division (BHSD) on the delivery of BH protocols to providers. The protocols will be used by BH providers to improve accuracy of information reported and establish guidelines for the types of BH providers who are required to report.
A daily review of incident reports is conducted by the MCOs and the HSD CI unit. Critical Incidents are being reported quarterly by each MCO. This data is trended and analyzed by HSD.

UHC coordinated with Presbyterian to transfer its Medicaid membership on September 1, 2018 and as a result, Q4 data for UHC is not reflected in the table. HSD continues to monitor the transition to ensure continuity of care for Medicaid members. UHC provides HSD with a weekly update regarding the single death investigation which is pending a report from of the Office of the Medical Investigator.

During DY5, 23,181 critical incidents were filed for Centennial Care, Behavioral Health and Self-Directed members. Of the 23,181 reports filed, 5,523 reports were submitted in Q4; 6,191 in Q3; 5,823 in Q2; and 5,644 in Q1. The number of Incidents filed by MHC for Q3 has increased since the publishing of the DY5Q3 report. This was due to unreported incidents not reflected in the MCOs quarterly data submission. HSD has revised DY5 Q3 totals to reflect this. One hundred percent of all CIRs received through the HSD Critical Incident web portal are reviewed. HSD continues to provide technical assistance to the MCOs when providers are non-compliant with reporting requirements.

During DY5, a total of 1,786 deaths were reported. Of the 1,786 deaths reported, 1,596 deaths were reported as natural, expected deaths, 181 deaths were reported as unexpected and nine were reported as suicides. All deaths reported through the critical incident system are reviewed by HSD and the MCOs.

All critical incident reports require follow up. Follow up can include medical record review, or records from the Office of the Medical Investigator (OMI) to determine a cause of death. MCOs have internal processes to follow up on all deaths.

During DY5, Centennial Care, Behavioral Health and Self-Directed populations reported a total of 12,898 (64.66 percent) critical incidents for Emergency Services. Of those Emergency Services reports, 844 were Behavioral Health and 1,149 were Self-Directed. MCOs collaborate with internal and external stakeholders to imitate new practices to establish member contact in attempts to better serve the member. HSD will continue to monitor any decreases or increases of emergency services reports.

Table 9 – DY5 Critical Incidents

Critical Incident Types by MCO - Centennial Care										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	178	0.89%	366	1.83%	429	2.15%	192	0.96%	1,165	5.84%
Death	439	2.20%	390	1.96%	569	2.85%	388	1.95%	1786	8.95%
Natural/Expected	399		335		492		370		1,596	
Unexpected	38		52		74		17		181	
Suicide	2		3		3		1		9	
Elopement/Missing	11	0.06%	35	0.18%	39	0.20%	6	0.03%	91	0.46%
Emergency Services	2,339	11.73%	3,060	15.34%	5,331	26.73%	2,168	10.87%	12,898	64.66%
Environmental Hazard	49	0.25%	54	0.27%	128	0.64%	79	0.40%	310	1.55%
Exploitation	54	0.27%	83	0.42%	112	0.56%	116	0.58%	365	1.83%
Law Enforcement	58	0.29%	110	0.55%	101	0.51%	51	0.26%	320	1.60%
Neglect	455	2.28%	458	2.30%	1,611	8.08%	487	2.44%	3,011	15.10%
Total	**3,583**	**17.96%**	**4,556**	**22.84%**	**8,320**	**41.71%**	**3,487**	**17.48%**	**19,946**	**100.00%**

Critical Incident Types by MCO - Behavioral Health										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	30	1.73%	186	10.71%	123	7.08%	15	0.86%	354	20.38%
Death	12	0.69%	39	2.25%	20	1.15%	10	0.58%	81	4.66%
Natural/Expected	7		28		12		5		52	
Unexpected	5		9		7		4		25	
Suicide	0		2		1		1		4	
Elopement/Missing	4	0.23%	15	0.86%	13	0.75%	0	0.00%	32	1.84%
Emergency Services	47	2.71%	611	35.18%	149	8.58%	37	2.13%	844	48.59%
Environmental Hazard	1	0.06%	5	0.29%	12	0.69%	1	0.06%	19	1.09%
Exploitation	3	0.17%	11	0.63%	12	0.69%	0	0.00%	26	1.50%
Law Enforcement	15	0.86%	34	1.96%	33	1.90%	4	0.23%	86	4.95%
Neglect	32	1.84%	148	8.52%	92	5.30%	23	1.32%	295	16.98%
Total	**144**	**8.29%**	**1,049**	**60.39%**	**454**	**26.14%**	**90**	**5.18%**	**1,737**	**100.00%**

Critical Incident Types by MCO - Self Directed										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	14	0.93%	21	1.40%	41	2.74%	18	1.20%	94	6.28%
Death	13	0.87%	12	0.80%	47	3.14%	17	1.13%	89	5.94%
Natural/Expected	12		9		39		15		75	
Unexpected	0		3		7		2		12	
Suicide	1		0		1		0		2	
Elopement/Missing	2	0.13%	4	0.27%	3	0.20%	0	0.00%	9	0.60%
Emergency Services	121	8.08%	154	10.28%	764	51.00%	110	7.34%	1,149	76.70%
Environmental Hazard	2	0.13%	0	0.00%	11	0.73%	1	0.07%	14	0.93%
Exploitation	3	0.20%	5	0.33%	18	1.20%	4	0.27%	30	2.00%
Law Enforcement	7	0.47%	6	0.40%	18	1.20%	3	0.20%	34	2.27%
Neglect	6	0.40%	10	0.67%	55	3.67%	8	0.53%	79	5.27%
Total	**168**	**11.21%**	**212**	**14.15%**	**957**	**63.89%**	**161**	**10.75%**	**1,498**	**100.00%**

Action Plans

MCOs proactively initiate internal Corrective Actions Plans (CAPs) throughout the year to address areas of noncompliance or areas for improvement. In DY5, HSD monitored each MCO's initiation, progress, and closure of CAPs, which were reported by the MCOs as follows: in DY5 Q1, nine CAPs in progress and three closed; DY5 Q2, eight CAPs in progress and one closed; DY5 Q3, twelve CAPs in progress and one closed; and DY5 Q4, five CAPs in progress and four closed. For additional details, summary and progress updates are provided with each quarterly report.

Evaluation Activities

Progress related to the Centennial Care 1115 Waiver Evaluation Design continued throughout DY5. Major activities and milestones consisted of continued efforts to collect data necessary to perform a final assessment of the program and detail the findings in the Final Evaluation Report.

The principal milestone achieved during DY5 was the submission of the draft Final Evaluation Report by the evaluator to HSD which consisted of the first four years of Centennial Care. The report provided detailed information related to the Centennial Care program design and goals, testable hypothesis and analyses, and findings for over one hundred performance measures to provide a basis for drawing conclusions on the effectiveness of Centennial Care.

The following provides a timeline of major activities that occurred in DY5 related to the drafting of the Final Evaluation Report:

- August 6th, initiation of the outline for the draft report;
- September 18th, completion of measure-level analysis and report content development;
- November 19th, submission of the first draft for HSD evaluation team and leadership review.

Discussions were held between Deloitte and HSD's evaluation team to address measure-level data changes and clarify report content. The evaluation team also had discussions with subject matter experts at HSD to review specific measures, relevant data, and methodology. Deloitte will continue to meet with HSD on a weekly basis to assess the status of the Final Report, as well as gather report content feedback and apply revisions.

Interim Findings

During DY5 Deloitte completed the Centennial Care Final Evaluation Report of DY1 through DY4. Highlights from the Final Evaluation report include:

- **Improving Access to Care** – Centennial Care combines Physical Health (PH), Behavioral Health (BH), and Long-Term Care and Support Services (LTSS) within a single consolidated waiver that establishes an integrated model of care. The Evaluation analyzes the impact of the Centennial Care model on service delivery and integration through the analysis of measures designed to address enrollment trends, timely access to care and services, geographic availability of care, care settings, and preventive health/wellness services.

  Through DY4, a lower percentage of adult members utilized preventive or ambulatory services across each of the three age cohorts and in aggregate when compared to the baseline, although, experience improved from DY3 to DY4 in two of the three age cohorts. The percentage of children and young adults that received dental visits was relatively consistent from the baseline to DY4. Throughout DY1 to DY4 there was a steady increase of members receiving dental visits. It is important to note the DY1 through DY4 experience was above the national averages for each year.

  The number and percentage of BH participants who received follow-up services after hospitalization of mental illness has also declined from the baseline to DY4, but similarly to annual dental visits, the DY4 experience exceeded 2017 national averages for both the 7-day and 30-day follow-up subcomponents. This may be indicative of the efficacy of the work that HSD has done in partnership with the MCOs to rectify the gaps in network coverage that occurred throughout DY2.

  With respect to preventive health/wellness services, immunizations for adolescents increased from the baseline to DY4 across each of the three immunization type subcomponents. Similarly, initiation and engagement of alcohol and other drug dependence (AOD) treatment has increased from DY1 to DY4 in each age cohort, for both the initiation and engagement subcomponents. Timeliness of prenatal care and receipt of postpartum care has declined from the baseline to DY4. However, increases were seen from DY2 to DY3.

- **Increased Member Engagement** – Centennial Care introduced a member rewards program intended to incentivize individuals to participate in state-defined activities that promote healthy behaviors. Members can earn rewards from adhering to refilling monthly prescriptions to getting an annual dental visit. Member participation in the Centennial Rewards program has increased from 7.1% in DY1 to 26.2% in DY4. The percentage for members earning rewards was just over 40% in DY1 but increased to over 72% by DY4.

- **Reducing Expenditures and Shifting to Less Costly Services** – A principal goal of Centennial Care is to meet budget neutrality requirements meaning that the total "with waiver" costs should not exceed the total "without waiver" costs. Through DY4 of the program costs continue to be budget neutral. Total program expenditures for DY4 of Centennial Care were approximately 28.1% below STC cost projections for DY4.

  The budget neutrality goal of Centennial Care is to also ensure that the "with waiver" PMPM costs for each MEG do not exceed the "without waiver" PMPM costs for each MEG. Furthermore, the State is not at risk for total expenditures because of increases in membership. The costs for all MEGs remained below the MEG PMPM cap throughout DY1 to DY4 apart from the NF LOC Dual group. Also, the PMPM costs for all MEGs experienced decreases in the range of 0.2% to 7.2% from DY3 to DY4, apart from the NF LOC group. The aggregate program PMPM decreased 3.8% from DY3 to DY4 and decreased 4.0% from DY1 to DY4. These decreases in PMPM by MEG demonstrates that the Centennial Care program is experiencing success with respect to cost containment, a principal goal of the program.

  Program savings were driven in part by the transition to less costly services, including greater utilization of outpatient services for managing substance abuse, an increase in the use of home and community-based services (HCBS), positive shifts in pharmacy utilization of generic drugs and continued reductions in in patient claims exceeding $50,000.00 as a percentage of healthcare costs.

- **Increased Member Satisfaction** – Centennial Care defines performance standards for contracted MCOs related to timely adjudication of member grievances and appeals, access to providers, and responsive customer service. These performance standards are intended, in part, to improve the member experience and increase satisfaction with the program.

  CAHPS survey results indicate a consistent increase in member satisfaction with care coordination from DY2 through DY4. These increases in satisfaction were seen across two of the three population cohorts, namely children with chronic conditions (CCC), and the general population ("Child General"). Similarly, the overall rating of health care has increased in the Child General and adult populations from the baseline to DY4, though the CCC population has seen a slight decline over the same period.

Quality Assurance Monitoring Activities

Care Coordination Audits

HSD continues to monitor quarterly progress reports evaluating care coordination activities from the MCOs. HSD conducted a meeting with each MCO in February 2018 to discuss progress related to action steps and recommendations, review results of MCO internal audits and provide feedback on MCO reporting. HSD also conducted follow up instruction with MCOs during Technical Assistance Calls in order to assist the MCOs in understanding the requirements of specific Action Steps and facilitate their successful completion. In DY5, HSD noted that the MCO's internal audit results for actions steps and recommendations showed improvement and HSD inactivated further reporting when MCO internal audit results demonstrated expected compliance for three consecutive quarters. Audit results were confirmed by HSD review. In DY5, HSD also added additional action steps for BCBS as a result of the 2015 and 2016 EQRO Compliance audit. These actions steps addressed improving the timeliness of completion of the HRA and CNA and ensuring all Notice of Adverse Benefit Determination letters utilize easily understood language. HSD will continue to work with the MCOs and monitor care coordination activities through regular audits and address findings during scheduled monthly care coordination meetings with each MCO.

Care Coordination for Super Utilizers

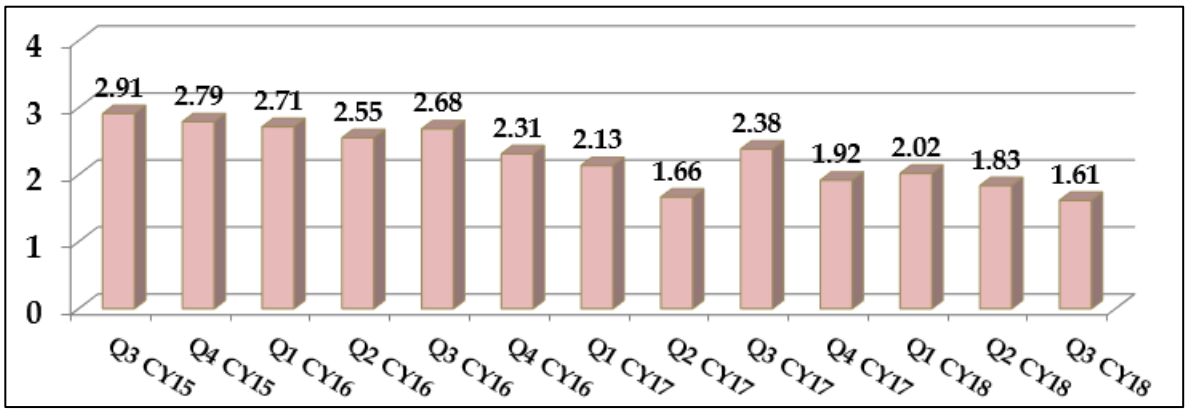
HSD utilized PRISM software to track members who were high utilizers of the Emergency Department (ED) from DY2 Q3 through DY5 Q4 and worked with the MCOs on implementing interventions to reduce unnecessary ED utilization.

- PRISM is an integrated software tool used to support care management interventions for high risk Medicaid patients.
- HSD utilized PRISM data to identify the MCOs' highest utilizers of the ED.
- In DY2, HSD began tracking the top 10 utilizers for each MCO. In DY3 HSD increased the number of members tracked to 35 of the top ED utilizers per MCO.
- During DY5, HSD monitored monthly reports on each "super utilizer" group, tracking the number of ED visits, supplemental care information and care coordination activities to reduce non-emergent ED utilization.
- HSD provided monthly feedback to each MCO targeting specific member issues and encouraging innovative methods of engagement.
- HSD conducted a presentation to all MCOs in DY5 Q1 detailing the progress seen to date in reducing non-emergent ED utilization. MCOs were given to opportunity to share best practices, challenges to engagement and successful approaches implemented.
    - Some of the initiatives and best practices utilized were:
    - Intensive engagement with Community Health Workers to accompany members to scheduled appointments;
    - Utilizing housing specialists to obtain housing for members and additionally connect with local agencies for needed furnishings;

- Presenting Project Super Utilizer members in "case rounds" meetings weekly to increase timely interventions;
- Expanding the connections with facility staff at local healthcare clinics, homeless shelters and methadone clinics as well as reinforcing relationships with staff at hospitals and residential treatment centers.

HSD received feedback from the MCOs that despite challenges with this project membership, they saw success in non-emergent ED reduction and have implemented some of the intensive interventions for a larger membership population.

The following graph illustrates the decline seen in average ED use over the period of the project showing the average ED visit per member declined for all MCOs by 44.67%.



Care Coordination Reports

HSD reviewed monthly data submitted by the MCOs for compliance with contract timeliness and member engagement. Due to inconsistencies in submitted data, HSD created a quarterly Ad Hoc report in DY5 Q1. HSD conducted a training with all MCOs in DY5 Q2 to detail the methodology to be used in the quarterly Ad Hoc report. Topics of the methodology training included contract definitions for categorizing members who are unreachable, difficult to engage or refused care coordination as well as determining touchpoint timeliness for members with a change of condition. HSD reviewed and analyzed the quarterly Ad Hoc report submissions from the MCOs while revising a standardized report to be implemented in DY5 Q1. The results of the Ad Hoc reviews prompted HSD to meet with each MCO on a monthly basis to discuss timelines of HRA and CNA completion as well as consistency in data submissions. HSD also discussed improvements in member engagement. HSD has received positive feedback from the MCOs relating to more frequent meetings resulting in timely clarification of HSD requirements and responses to MCO questions.

Care Coordination and EDIE System

The Emergency Department Information Exchange (EDIE) is an MCO collaborative effort utilized to promote appropriate ED utilization. EDIE was launched in July of 2016 and EDIE allows the MCOs to increase the impact of their existing care coordination resources by automatically aggregating a full census of all ED admissions, inpatient admissions, transfers, observations and discharges. EDIE is directly integrated with the hospital Electronic Medical Record (EMR), which automatically alerts EDIE and then identifies the patient and references visit history, even if key information is missing from the patient's hospital record. If a visit triggers a pre-set criterion, EDIE notifies the provider within seconds. Notifications to the provider contain visit history, diagnoses, prescriptions, guidelines, and other clinical metadata. Because of the notification, the provider has information in hand before seeing the patient. This allows the provider to act to influence health care outcomes. HSD attends bi-monthly meetings with MCOs, the New Mexico Hospital Association, the New Mexico College of Emergency Physicians, other state agencies and community providers that use the EDIE system and have worked to get state wide participation. The number of participants has increased with 34 of 38 New Mexico hospitals using EDIE and 3 in progress to go live in DY6 Q1. All 76 Skilled Nursing Facilities anticipate going from the current implementation stage to live in DY6. Progress was made in DY5 to include hospitals in neighboring states that often provide care to New Mexico residents. Users of the EDIE system have reported an increased ability to engage timely with members and to connect them to appropriate, needed services. Care coordinators, Community Connectors and Community Health Workers have continued to develop relationships with hospital and nursing facility staff to better connect with those members that are difficult to engage. New Mexico is challenged with large rural and frontier areas where access to healthcare may be limited. Connecting difficult to engage members to care coordinators through EDIE allows the member to be referred to a variety of services and options for which they are eligible. Hospital administrators have been able to connect with skilled nursing facility users as well as interested state agencies to bring best practices to the table for future innovations. EDIE also includes a Prescription Monitoring Program that allows users to quickly see what medications a member has been prescribed and monitor appropriately. Regular tracking of EDIE usage is reported bi-monthly, training sessions for new users occurs monthly, follow-up training for current users occurs regularly and webinars are distributed weekly to explain and reinforce the clinical importance of EDIE.

Care Coordination Ride-Alongs

HSD continues to conduct "ride-alongs" with MCO care coordinators. In DY5, "ride-alongs" were conducted with all four MCOs with staff observing initial, annual or semi-annual CNAs in member's homes. During "ride-alongs" HSD staff observe care coordinator interviewing styles, member engagement techniques, whether contract required information is obtained and whether all resources and services are presented. HSD observed members receiving services through both Agency Based Waiver and Non-Waiver models as well as members participating in Self-Directed services. All "ride-alongs" conducted in DY5 occurred in member homes with some including additional family members and caregivers. HSD noted that all care coordinators, observed in DY5, complied with contract requirements and had interviewing styles that connected with their members. Observations during future "ride-alongs" will inform what additional information may be included in DY6 care coordination training.

Service Plans

HSD continues to randomly review service plans to ensure that the MCOs are using the correct tools and processes to create service plans. The review of service plans also ensures the MCOs are appropriately allocating time and implementing the services identified in the member's comprehensive needs assessment, and the member's goals are identified in the care plan. There were no identified concerns for DY5.

Table 10 – 2018 Service Plan Audit

Service Plans	Quarter 1 2018	Quarter 2 2018	Quarter 3 2018	Quarter 4 2018	DY5 Totals
Member files audited	120	120	110	90	440
Percent of service plans with personalized goals matching identified needs	100%	100%	100%	100%	100%
Percent of service plans that hours allocated matched need	100%	100%	100%	100%	100%

Nursing Facility Level of Care (NF LOC)

HSD reviews Nursing Facility High LOC denials and community benefit NF LOC denials on a quarterly basis to ensure the denials were appropriate and comply with NF LOC criteria. HSD agreed with all but one BCBS decision, a Community Benefit NF LOC denial in DY5 Q4. Documentation in the CNA indicated that member met criteria for LNF; however, the member was denied NF LOC by Utilization Management (UM) staff. HSD followed up with BCBS regarding this discrepancy and BCBS confirmed that decision to deny NF LOC by the UM reviewer was inaccurate. A new CNA was conducted on 1/10/19 and the new determination resulted in the member being approved for PCS. BCBS also noted that the UM reviewer who completed this review had been coached regarding this issue and general reminder will be provided to their NF LOC review team to ensure NF LOC decisions accurately reflect ADL information captured in documentation.

Table 11 – 2018 NF LOC Audit

Service Plans	Quarter 1 2018	Quarter 2 2018	Quarter 3 2018	Quarter 4 2018	DY5 Totals
High NF LOC requests denied (and downgraded to Low NF)					
Number of member files audited	15	12	11	10	48
Number of member files that met the appropriate level of care criteria	15	12	11	10	48
Percent of MCO level of care determination accuracy	100%	100%	100%	100%	100%
Low NF LOC requests denied (Community Benefit)					
Number of member files audited	25	25	25	17	92
Number of member files that met the appropriate level of care criteria	25	25	25	16	91
Percent of MCO level of care determination accuracy	100%	100%	100%	94%	99%

The External Quality Review Organization (EQRO) for HSD reviews a random sample of MCO NFLOC determinations every quarter.

Table 12 – 2018 EQRO NF LOC Review

Facility Based	Quarter 1 2018	Quarter 2 2018	Quarter 3 2018	Quarter 4 2018	DY5 Totals
High NF Determination					
Number of member files audited	23	22	23	48	116
Number of member files the EQRO agreed with the determination	22	22	19	37	100
%	96%	100%	83%	77%	86%
Low NF Determination					
Number of member files audited	85	106	134	77	402
Number of member files the EQRO agreed with the determination	85	102	122	64	373
%	100%	96%	91%	83%	93%
Home and Community Based					
Number of member files audited	156	176	198	156	686
Number of member files the EQRO agreed with the determination	152	176	192	154	674
%	97%	100%	97%	99%	98%

HSD reviewed NFLOC determination disagreements from EQRO audits from DY5. Issues identified included: conflicts in documentation, incomplete supporting documentation, and supporting documentation dated outside the required time period. HSD reviewed determination disagreements with the MCOs via deliverable in DY5. All four MCOs provided clarification regarding identified issues and reviewed their internal procedures to monitor quality and plans moving forward to further improve accuracy. HSD noted that the number of MCO High NF determination disagreements increased over the course of DY5, with the EQRO in agreement with 77% of the MCO determinations in Q4 compared to 96% in Q1.MCO HNF determinations totaled 86% overall for DY5. The MCO Low NF determinations also decreased over the course of DY5 from 100% in Q1 to 83% in Q4, with a total of 93% overall for DY5. Community based determinations consistently totaled 97% or above for EQRO agreement with a total of 98% overall for DY5. HSD will continue to monitor the EQRO audit of MCO NF LOC determinations to identify and address any trends requiring MCO technical assistance as needed.

Post Award Forum

The Centennial Care post award forum was held on Monday, November 5, 2018 as part of a regular Medicaid Advisory Committee (MAC) meeting. The state invited the public to participate in a public forum and provide meaningful comments about Medicaid's Centennial Care program since implementation. The State looks forward to receiving the public's feedback about its managed care program annually. HSD did not receive any comments at the Centennial Care post award forum.

SECTION III: TOTAL ANNUAL EXPENDITURES

Table 13 – Waiver Year 5 Expenditures

Medicaid Eligibility Group (MEG)	Program Expenditures	Administrative Expenditures
MEG01 - TANF & Related	$ 1,409,054,435	$ 83,751,868
MEG02 - SSI & Related - Medicaid Only	$ 791,312,991	$ 8,801,960
MEG03 - SSI & Related - Dual Eligible	$ 552,584,591	$ 8,214,888
MEG04 - "217 Like" Medicaid Only	$ 12,001,420	$ 75,982
MEG05 - "217 Like" Dual Eligible	$ 133,736,825	$ 885,653
MEG06 - VIII Group - Medicaid Expansion	$ 1,447,565,532	$ 61,698,109
MEG07 - CHIP	$ 96,450,745	$ 9,620,095
Uncompensated Care "UC" Pool	$ 51,666,996	N/A
Hospital Quality Improvement Incentive "HQII" Pool	$ -	N/A
Grand Total	$ 4,494,373,535	$ 173,048,555

Source: New Mexico CMS 64 Submission, FFY19 Quarter 1, January 31, 2019

SECTION IV: YEARLY ENROLLMENT REPORT

Table 14: DY5 Enrollment

Demonstration Population	WY4 Member Months (as of 1/3/19)	WY4 Enrollment (as of 1/3/19)
Population 1 – TANF and Related	1,081,476	361,557
Population 2 – SSI and Related – Medicaid Only	114,388	38,260
Population 3 – SSI and Related – Dual	106,121	36,113
Population 4 – 217-like Group – Medicaid Only	996	310
Population 5 – 217-like Group – Dual	12,014	4,162
Population 6 –Group VIII (expansion)	750,077	269,896
Totals	2,065,072	710,298

Note: This data was extracted on January 3, 2019. Due to retro-active eligibility, member months continue to increase slightly after the end of the waiver year.

SECTION V: MANAGED CARE DELIVERY SYSTEM

Accomplishments

Centennial Care Improvements

- The primary care provider-to-member ratio standard of 1:2,000 was met by all MCOs in urban, rural, and frontier counties.
- To expand telemedicine services, one MCO has been working with an urgent care provider on a new telemedicine service model that addresses the limitations of the standard telemedicine visit (e.g., vital signs) and does not require the member to have a computer or smart phone. A paramedic is sent to the member's home where vital signs are taken, and other information typically collected by a nurse in an office or urgent care setting. The paramedic accesses the urgent care provider through telemedicine equipment.
- To better capture the member's social determinants of health (SDOH) needs, one MCO added evidence-based questions from the "Health Leads Social Needs Screening Toolkit" into its medical management system. As social needs are identified during the Comprehensive Needs Assessment goals and interventions are automatically generated in the member's Care Plan. Outcomes data will be measured for future program enhancements.
- Recognizing that some difficult to engage members have behavioral health issues that may lead to self-harm, harm to others, or increased use of the Emergency Department (ED) or hospitalization, one MCO created a team with specialized training to engage this difficult population for care coordination engagement. The team will be able to complete assessments and triage any urgent issues at the time of initial contact. The project will pilot in the larger urban areas of New Mexico focusing on populations with high ED/hospital usage and homelessness. Anticipated outcomes include increasing participation in care coordination and reducing ED/hospital utilization by addressing the member's health needs.
- One MCO piloted a program that addresses the needs of members with signs of memory loss or who are diagnosed with dementia. The program provides Amazon Echo Dots to these members, which are programmed to remind them to perform key activities at set times during the day such as medication reminders, drinking water, preparing and eating meals, and attending provider appointments. The program has the potential to ease the burden on family members or caregivers.

Report Revisions

Report revisions are necessary for HSD to improve the monitoring of MCO performance, streamline elements from various reports, and incorporate requirements of the managed care final rule, etc. Throughout DY5, 17 of the 31 reports underwent the revision process in preparation for Centennial Care 2.0. Report revisions are initiated through a formal written process in which HSD and MCOs request needed changes to data elements. HSD Subject Matter Expert's continued to revise the selected reports to ensure the needs of all stakeholders are considered.

Improved Reporting Process

HSD utilizes MCO reports to monitor contract compliance and MCO performance. During DY5 Subject Matter Experts (SMEs) continued to participate in Technical Assistance (TA) calls with the MCOs. MCOs continued with the process of submitting Self-Identified Error Resubmissions for report corrections. These two processes allow HSD and MCO SMEs to clarify data requirements and correct data inaccuracies. HSD is dedicated to obtaining accurate, complete and uniform data elements as the information received from the MCOs is used for a variety of analyses including state budget, legislative reports, and external stakeholder meetings.

Health Homes

On April 1, 2016 HSD launched the first two Health Homes, CareLink NM (CLNM), with a designated population of adults with serious mental illness and children/adolescents with severe emotional disturbance. On April 1, 2018 HSD implemented Health Homes services in eight additional counties with seven providers to address the same target population. The CLNM model in all sites provides for enhanced care coordination and integration of primary, acute, behavioral health, long term care services and social supports.

Goals include: 1) Promoting acute and long-term health; 2) Preventing risk behaviors; 3) Enhancing member engagement and self-efficacy, 4) Improving quality of life for members with SMI and SED; and 5) Reducing avoidable utilization of emergency department, inpatient, and residential services. These goals serve as the foundation for establishing both quality process standards and evaluation criteria for outcomes.

The development of the automated information system, BHSDStar, was activated on April 1, 2017 and launched with data modules for registration, service planning and documentation, and interfaces to the Medicaid system. Since then, the comprehensive needs assessment portion of the system has been finalized, and a variety of system enhancements have been implemented. Reporting and service tracking functions have been developed and are being enhanced in response to requests from providers.

Delivery System Improvement Performance Targets (DSIPTs)

The DSIPTs allow MCOs to be recognized for their quality improvements in specific areas. In DY1 and DY2, HSD required four target areas for DSIPTs. In DY3 and DY4, HSD expanded target areas by adding emphasis on five specific areas. HSD is currently evaluating the 2018 MCO results for DSIPT targets for DY5, which allows recognition of quality improvements, in the following five areas:

A. *Community Health Workers* – Increase the use of Community Health Workers (CHWs) with continued development of the workforce, for care coordination activities, health education, health literacy, translation and community support linkages in rural, frontier, and underserved communities in urban regions of the state.

Community Health Worker 2018 Results - To-date in DY5 Q3 a total of 55,869 MCO members were served by CHWs for a total increase of 49 percent since the 2015 baseline year. Each MCO utilized CHWs to expand services well above the 10 percent goal of members served. HSD will review the final increase results with the submission of MCO DY5 Q4 reports. The goal for 2019 will be 3 percent of the Contractor's total member enrollment being served by a CHW.

B. *Patient Centered Medical Home* - A minimum of a five percent (5%) increase of members being served by Patient-Centered Medical Homes (PCMHs) or maintain a minimum of 45% of membership being served by a PCMH (including both PCMHs that have achieved NCQA accreditation and those that have not).

Patient Centered Medical Homes 2018 Results - To-date in DY5 Q3 a total of 332,450 members were being served by a PCMH. HSD will review the final results with the submission of MCO 2018 complete PCMH data.

C. *Hepatitis C* - During the DY5 contract period, MCOs must meet at least 80% of the MCO's target number of patients receiving Hepatitis C drug treatments for the combined Physical Health, Medicaid Only LTSS, and Other Adult Group populations.

Hepatitis C 2018 Results - As of March 7, 2019, utilizing the DY5 Q3 encounter data available to date, the preliminary target number of members to be treated was 1,400 for all MCOs and an estimated 1,275 members have been treated. HSD will be working with the encounter data at a later date when encounters are more complete to evaluate each MCO's performance.

D. *Value Based Purchasing* – In 2018 MCO's must meet a minimum of 20% of payments in VBP arrangements. Additionally, at least 3% of the required 20% must be with high volume hospitals and require a readmission reduction target of at least 5% of the hospitals CY17 baseline.

Value Based Purchasing 2018 Results – Final reporting will be submitted to HSD on May 15, 2019. Since the reporting is based on paid claims, HSD has allowed the MCO's to have a runout that matches the current runout on Financial Reporting.

E. *Telemedicine* - A minimum of a 15 percent increase in telemedicine "office" visits with specialists, included Behavioral Health providers, for Members in rural and frontier areas. At least five percent of the increase must be visits with BH providers.

Telemedicine 2018 Results – Utilization of telemedicine continues to increase. To-date in DY5 Q3 a total of 24,514 telemedicine visits were reported for all MCOs with 3,615 physical health telemedicine visits and 20,890 behavioral health telemedicine visits. HSD will review the final increase results with the submission of MCO DY5 Q4 reports.

Community Health Workers

In DY5, all four MCOs included the use of Community Health Workers (CHWs) to serve diverse ethnic groups in New Mexico's rural, urban, and frontier settings. CHWs are culturally diverse and trained to access the Social Determinants of Health (SDoH) needs to improve health outcomes by offering culturally appropriate education to address barriers to care, teach skills to manage treatment or prevent disease, along with linking individuals to health and social systems. MCOs have included CHWs as part of Delegated Care Coordination to inform care teams.

MCOs reported CHW workforce data for CHWs employed or contracted, for the purpose of HSD tracking workforce development. HSD is using data from DY5 Q3 due to claims runout for the annual report. The total to-date in DY5 Q3 of 138 CHWs represents a 34 percent increase from the year-end total of 91 in DY4. Training continues in state-endorsed certification programs through community colleges with internships to be offered by the MCOs. Please see Table 15: Year-over- year growth of the CHW workforce.

Table 15 – Year-over-Year Growth of Community Health Workers

CHW Workforce Detail		
1st Year Results CY16	2nd Year Results CY17	3rd Year Result Q3CY18
69	91	138

Source: [MCO] DSIPTs, DY4

SDoH needs assessments directly inform the interventions needed by Medicaid recipients. Some of the types of CHW interventions reported by the MCOs in DY5 included:

- Food Assistance
- Housing Assistance
- Identifying community-based providers and services
- Assisting members directly in making appointments to social services agencies
- Checking EMR for recommended medical screening, pending lab tests or referrals
- Assistance with Medicaid, income support, SNAP, housing, employment, education, or other government programs and services paperwork
- PCP engagement with making appointments and setting up transportation
- Chronic disease management
- Recovery supports for addiction
- ED alternatives for non-emergent care
- Nurse Advice Line, education
- NM Crisis and Access Line, education
- Urgent Care, education

The MCOs reported a 35 percent increase in DY5 Q3 from the 2nd year DY4 baseline target, after a 44 percent increase of Medicaid Members served was reported in DY4 from the 1st year DY3 baseline target, as a result of the ongoing and successful development of the CHW initiative by the MCOs. HSD will provide the final DY5 data in the upcoming DY6 Q1 report due to claims runout. Please see Table 16: Year-over-Year Unduplicated Members.

Table 16: Year-over-Year Unduplicated Members

	Baseline	1st Year CY16		2nd Year CY17		3rd Year CY18	
	2015 Unduplicated Members Served	Target 5% Increase	2016 YTD Total	Target 10% Increase	2017 YTD Total	Baseline Target 10% Increase	2018 thru Q3
BCBS	20,714	21,750	27,736	23,925	32,923	26,318	37,228
MHC	3,138	3,295	5,822	3,624	8,255	3,987	5,249
PHP	2,000	2,100	3,822	2,310	5,387	2,541	7,011
UHC	2,600	2,730	3,730	3,003	6,488	3,303	6,381
Total	28,452	29,875	41,110	32,862	53,053	36,149	55,869

Source: MCO DSIPT CHW Reports -Q1CY14-Q3CY18

From the baseline year of DY2, MCOs have increased unduplicated Members served by 49 percent to-date in DY5 Q3, with a total to date of 55,869 unduplicated Members served.

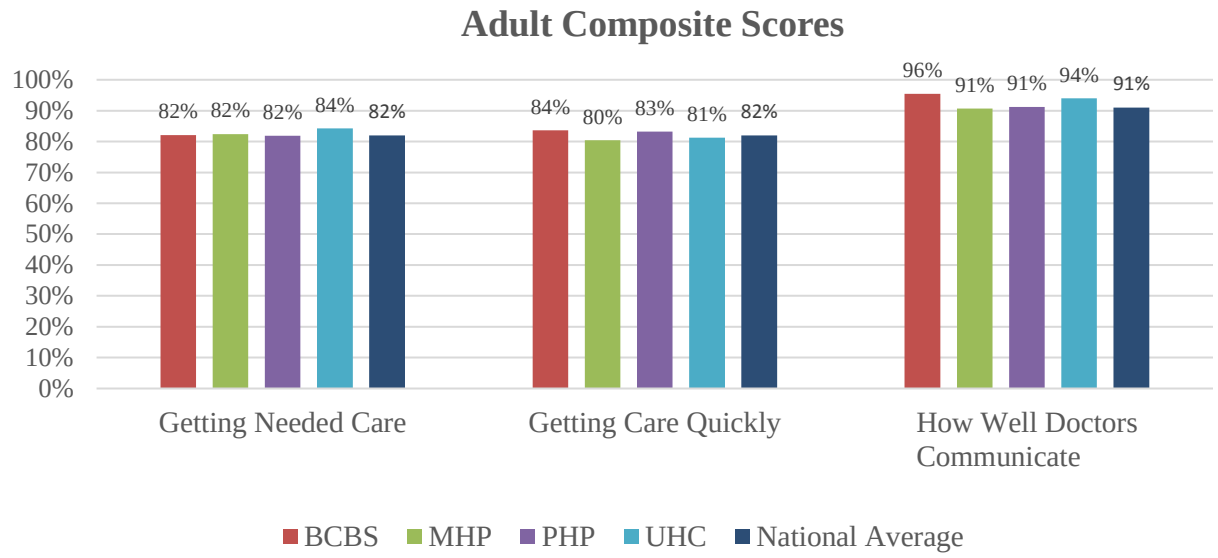
Utilization Data

Centennial Care key utilization and cost per unit data by overall program as well as by specific program for DY4 and DY5 can be found in Attachment F: Key Utilization/Cost per Unit Statistics by Major Population Group.

CAHPS Survey

Centennial Care MCOs are required to submit the Consumer Assessment of Healthcare Providers and Systems (CAHPS) results report on an annual basis with data collected from the prior year on adults, children, and children with chronic conditions (CCC). HSD worked with the MCOs to ensure inclusion of survey questions that would capture data for specific components of Centennial Care.

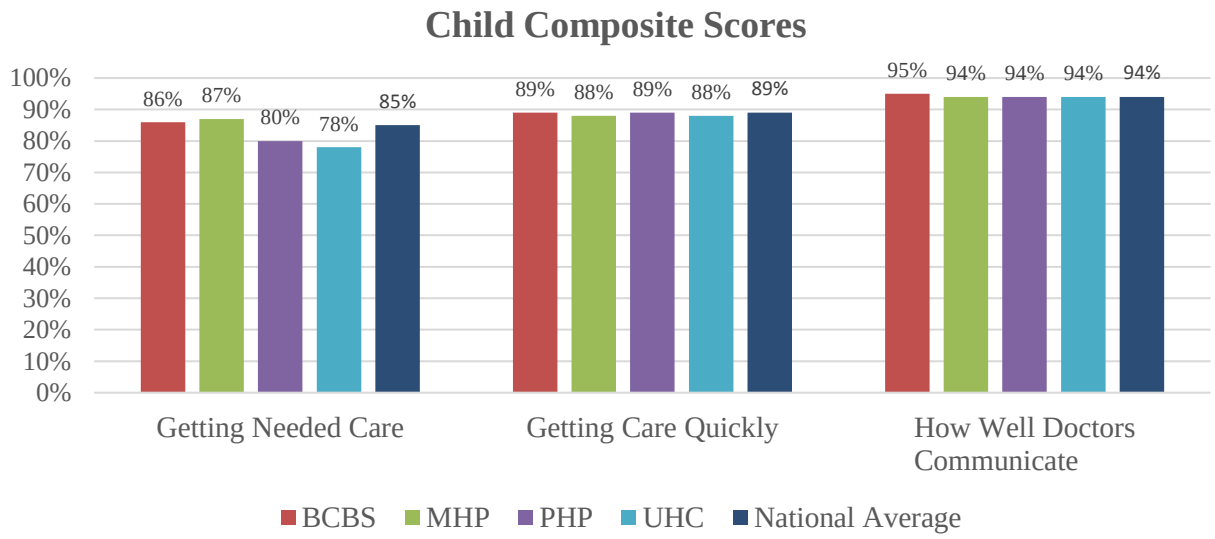
The chart below reflects aggregate percentages of the MCOs compared to national averages for the adult composite scores.

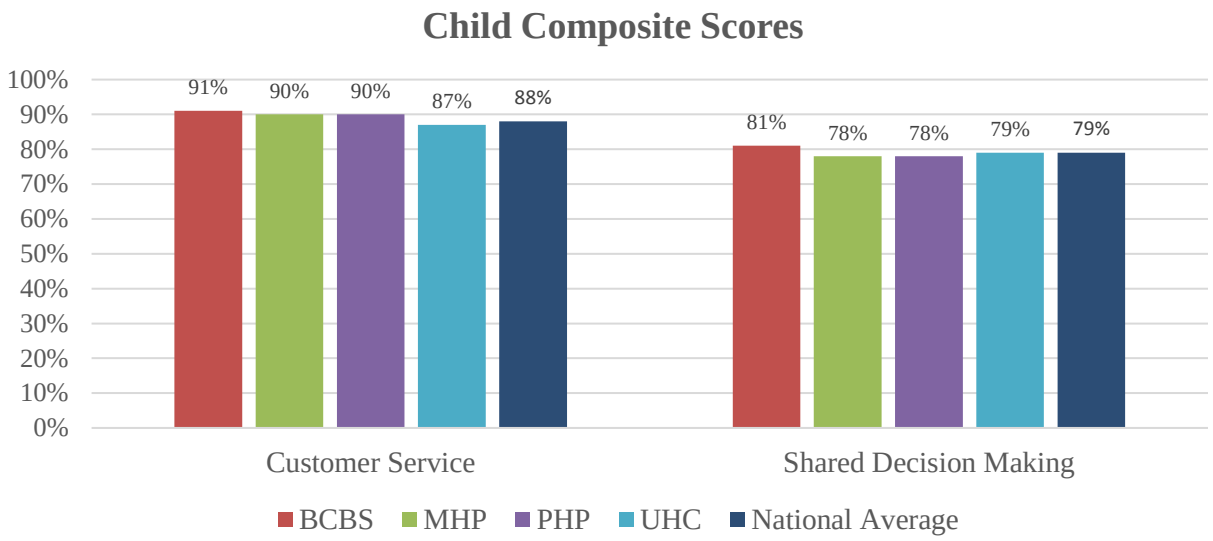


Conclusions:

All four MCOs were at or above the national average for "Getting Needed Care". Two of the MCOs, BCBS and PHP were at or above the national average for "Getting Care Quickly". All four MCOs were or above the national average for "How Well Doctors Communicate". BCBS, PHP and UHC were at or above the national average for "Customer Service". PHP and UHC were at or above the national average for "Shared Decision Making".

The chart below reflects aggregate percentages of the MCOs for the child composite scores:

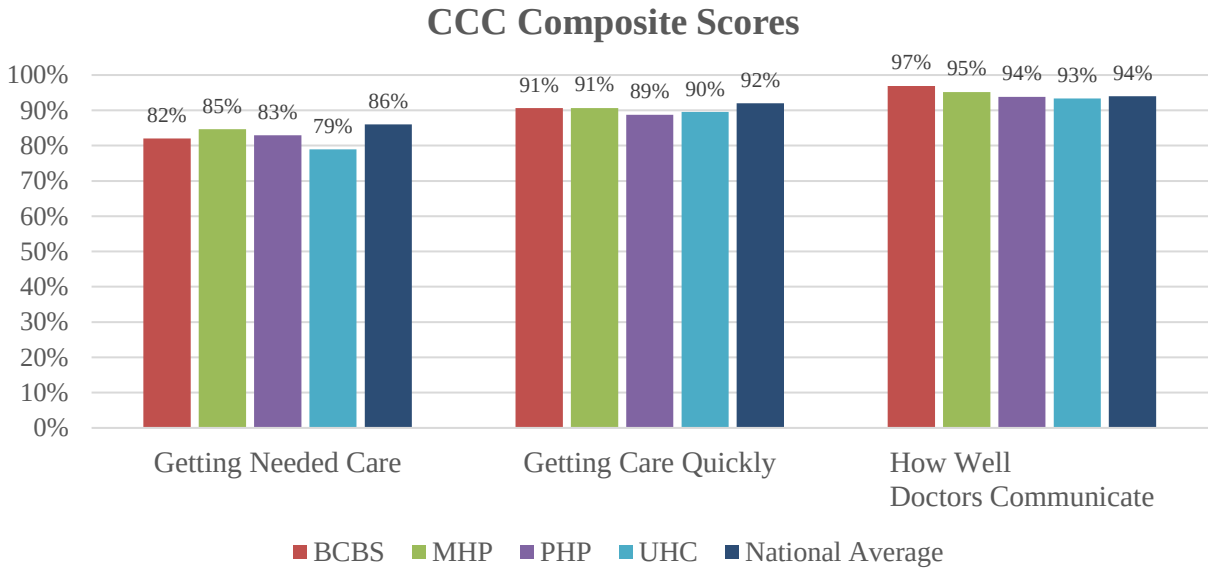


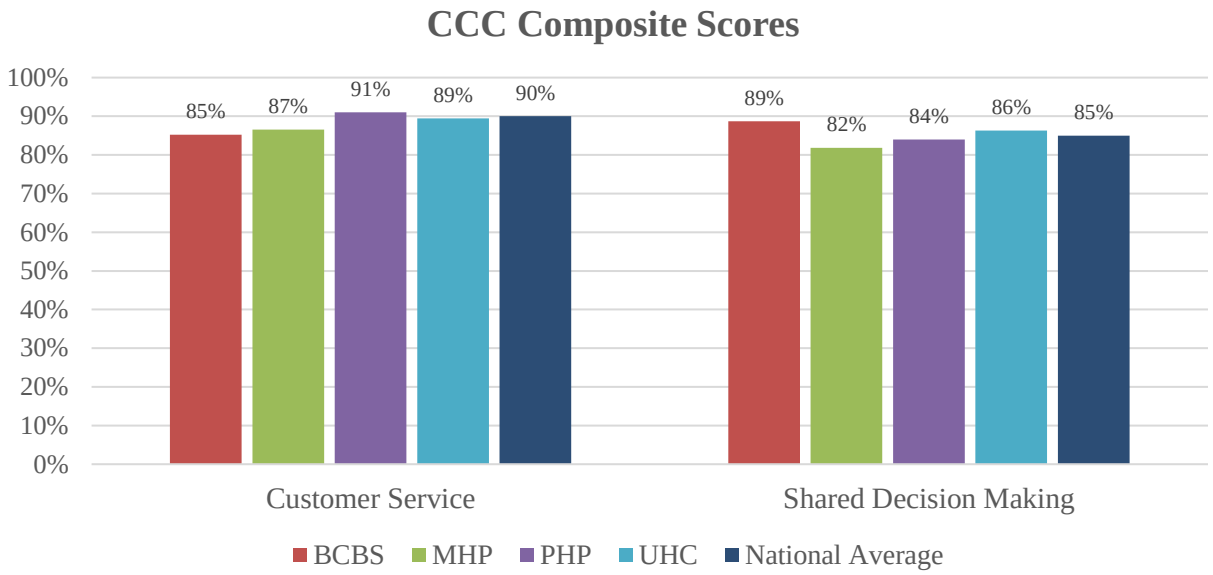


Conclusions:

Of the four MCOs, BCBS and MHC were at or above the national average for "Getting Needed Care". BCBS and PHP were at or above the national average for "Getting Care Quickly". All four MCOs were at or above the national average for "How Well Doctors Communicate". BCBS, MHC and UHC were at or above the national average for "Customer Service. BCBS and UHC were at or above the national average for "Shared Decision Making".

The chart below reflects aggregate percentages of the MCOs for the CCC composite scores:



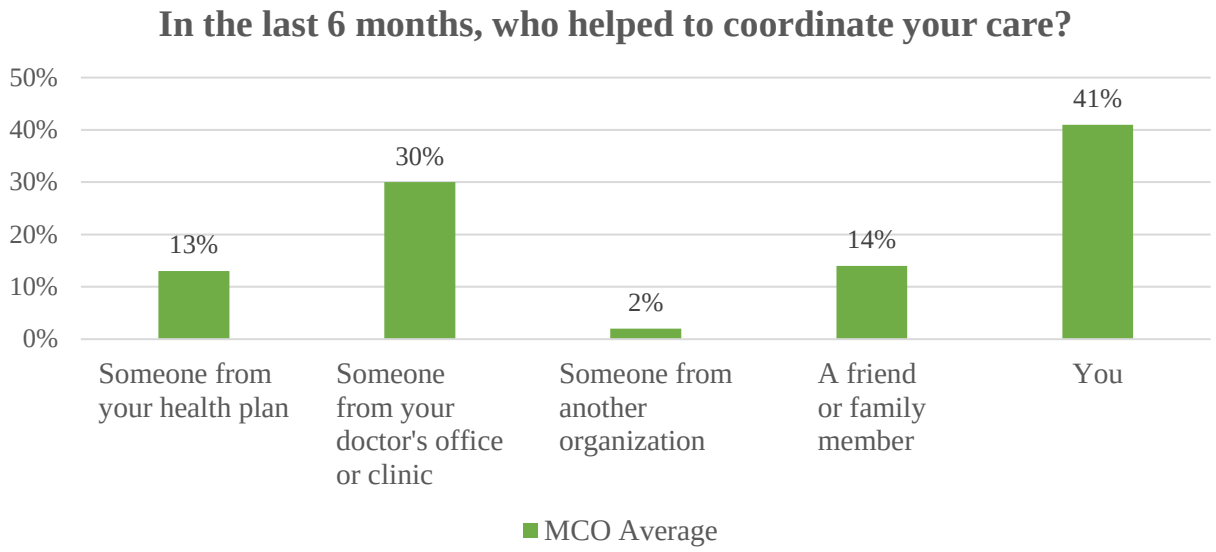


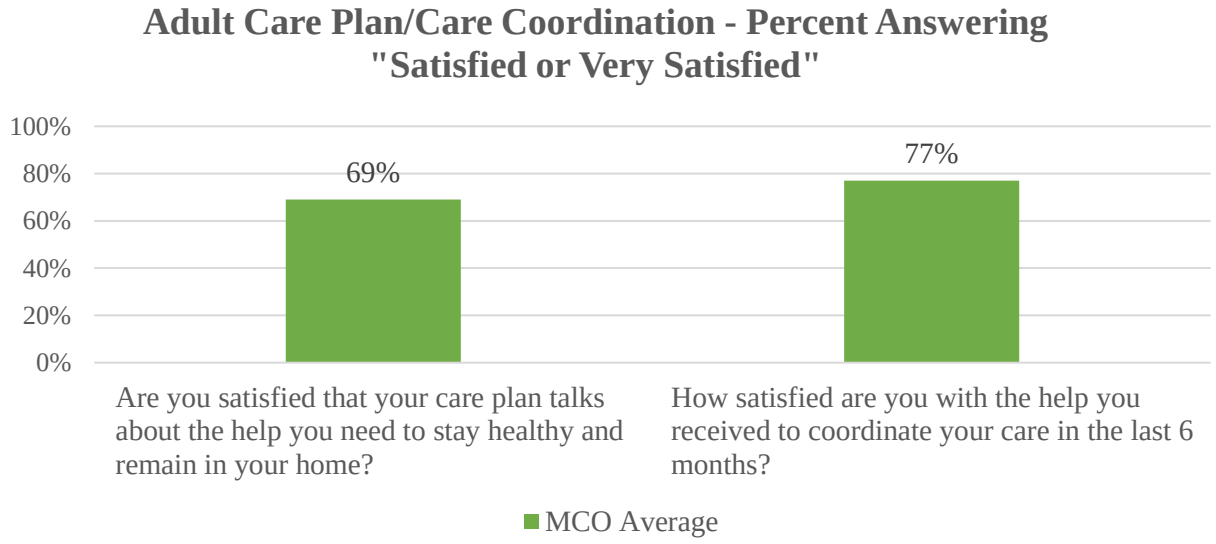
Conclusions:
Of the four MCO MHC was only one percentage point below the national average for the "Getting Needed Care". BCBS and MHC were one percentage point below the national average for "Getting Care Quickly". BCBS, MHC and PHP were at or above the national average for "How Well Doctors Communicate". PHP was above the national average for Customer Service". BCBS, PHP and UHC were at or above the national average for "Shared Decision Making".

In addition to the standard CAHPS 5.0 survey questions, HSD required the MCOs to include fourteen (14) additional questions that were approved by the National Committee Quality Assurance (NCQA) for the 2018 CAHPS survey. To review the complete CAHPS results, please visit the HSD website at:
http://www.hsd.state.nm.us/LookingForInformation/2016-cahps-reports.aspx

NCQA Approved Additional Care Coordination Questions (Adult)

The charts below show the percentages for the adult care coordination and member education additional questions that HSD required the MCOs to include. No national averages are reported for these measures.





Conclusion:
Survey responses indicate that members and their healthcare providers are most involved in the coordination of the member's care.

NCQA Approved Additional Member Satisfaction Questions (Adult)

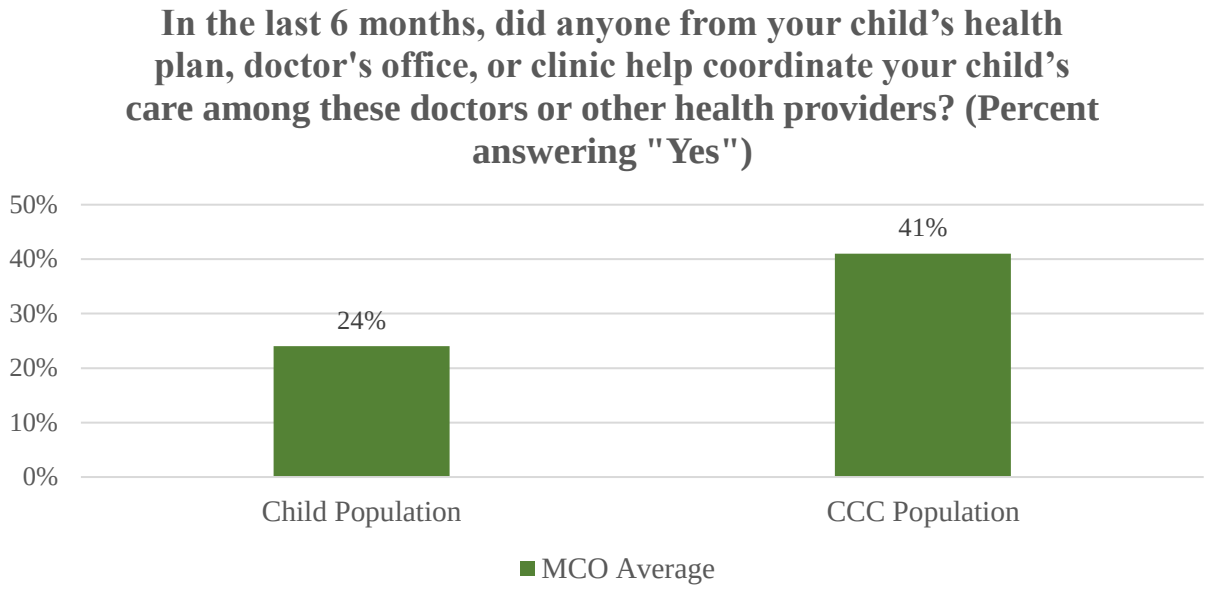
The chart below shows the percentages of adult members' satisfaction with their care plan and care coordination based on the additional questions that HSD required the MCOs to include. No national averages are reported for these measures.

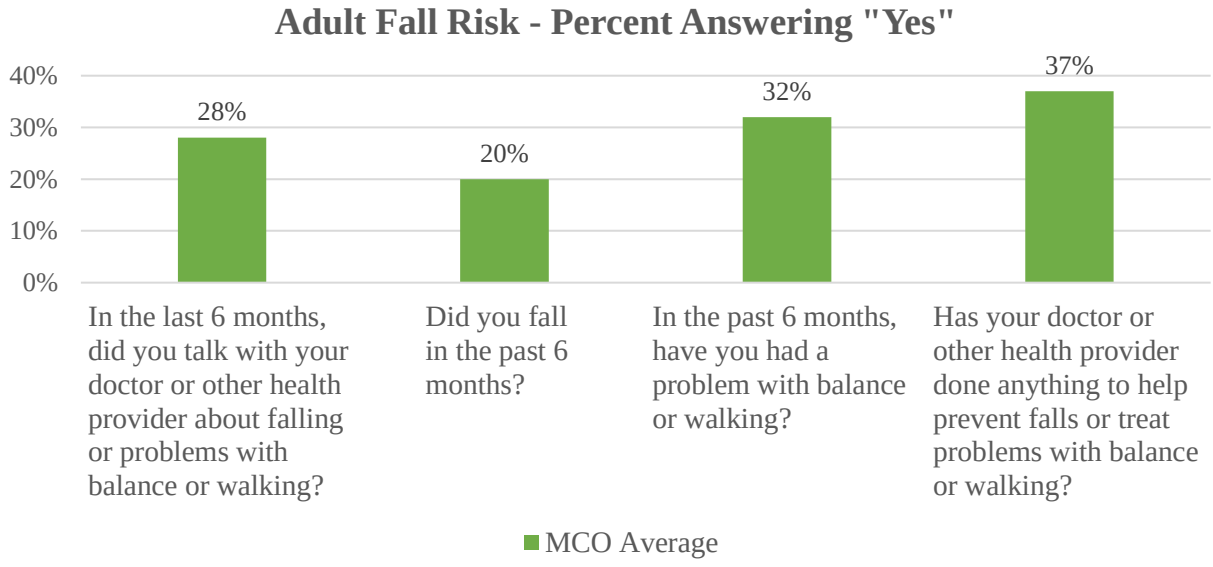
Conclusions:

Seventy seven percent of members surveyed are satisfied with the help they received to coordinate their care.

NCQA Approved Additional Questions Fall Risk (Adult)

The chart below shows the percentages for the adult fall risk additional questions that HSD required the MCOs to include. No national averages are reported for these measures.





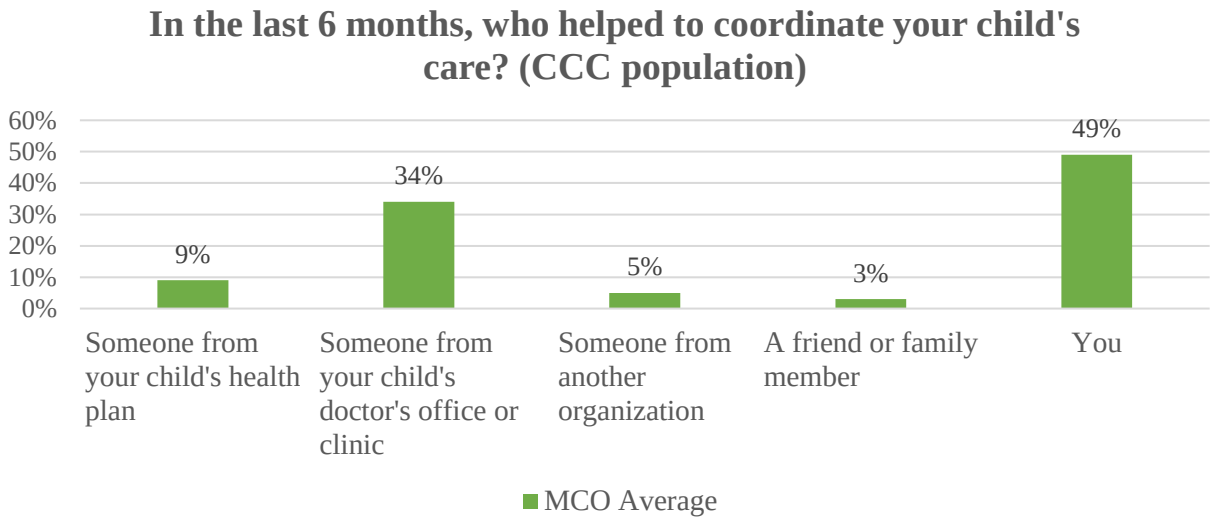
Conclusions:

Member responses indicate; an average of 26% of members surveyed reported a fall or a problem with balance or walking; and attention to identifying and treating falls and fall risks among

healthcare providers aligns with the members' responses with experiencing falls or problems with balance or walking.

NCQA Approved Additional Questions Care Coordination (Child)

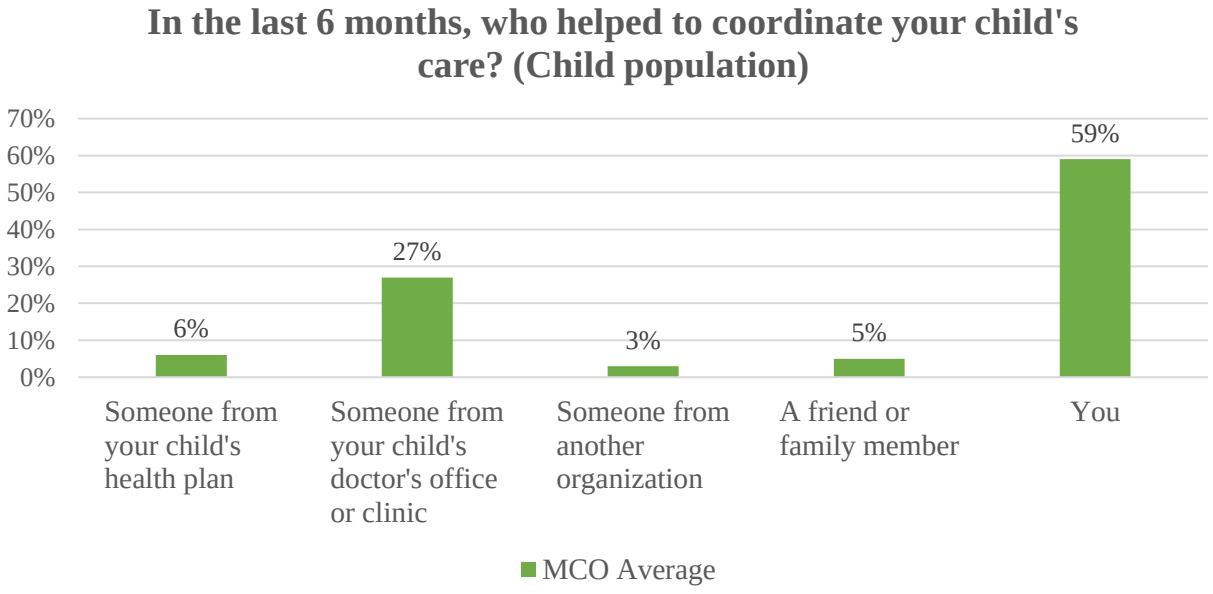
The chart below reflects aggregate percentages of the MCOs for the additional questions for the child survey HSD required the MCOs to include. The results reported are for the child population and the children with chronic conditions populations. There are no national averages reported for these measures.

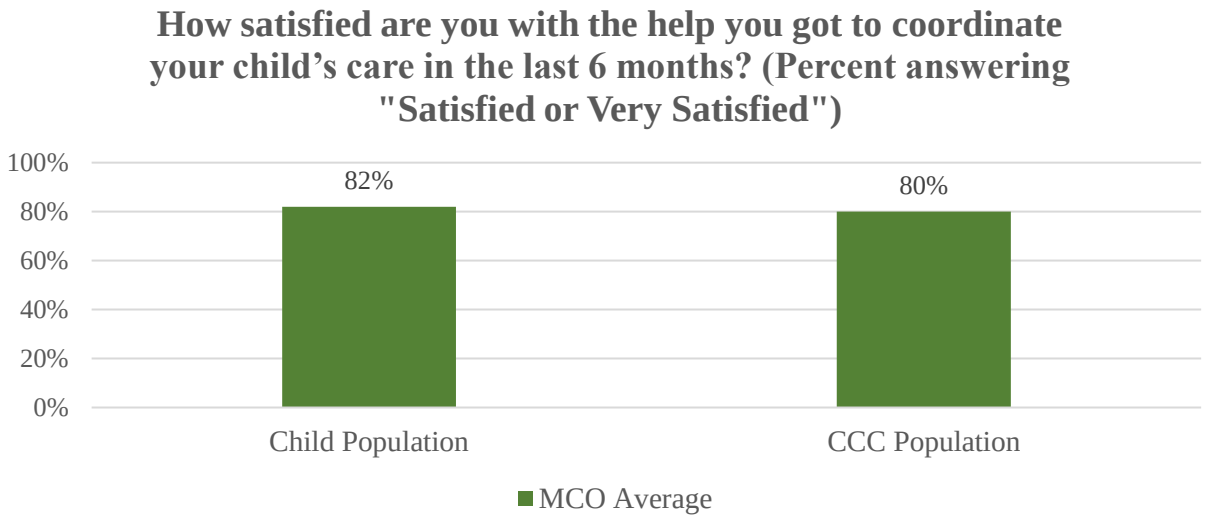


Conclusion:
Members and their healthcare providers are most involved in the coordination of care.

NCQA Approved Additional Questions Member Satisfaction (Child)

The chart below shows the percentages of child and CCC members' satisfaction with their care plan and care coordination based on the additional questions that HSD required the MCOs to include. No national averages are reported for these measures.





Conclusions:

Eighty-two percent of all members surveyed are satisfied with the help they received to coordinate their child's care and eighty percent of all members surveyed are satisfied with the help they received to coordinate their child's care in the CCC population.

Annual Summary of Network Adequacy by Plan

HSD evaluates and provides feedback to each MCO on their respective annual Provider Network Development and Management Plan that retrospectively evaluates the prior year and the coming year. The MCO's plans must be sufficient to ensure that all medically necessary covered services are accessible and available for the current and new population, as well as assess the current unmet needs and future needs related to membership changes.

MCOs utilize Report #3, the Network Adequacy Report, to evaluate provider ratios, Report #53 Primary Care Provider (PCP) to evaluate PCP member ratios, open panels and change activity, and Report #55, the GeoAccess Report, to evaluate distance requirements to providers as key elements to inform their decisions. HSD tracks the progress of each MCO in meeting GeoAccess standards quarter-over-quarter and focuses on improvements to distance requirements where standards are not being met. Please also see Attachment D – GeoAccess PH Summary.

- BCBS reported stable enrollment from December 2017 to September 2018 with an increase of 665 or 0.6%. BCBSNM demonstrated a stable provider network with a total of 13,662 contracted providers which includes an increase of 240 unique providers as compared to the previous report.

- MHC reports that their membership increased slightly from December 2017 to September 2018 by 421 members or +0.2%. MHNM reported 3,473 active contracts representing 13,807 individual practitioners and facility providers. MHC was not selected as a Managed Care Organization for New Mexico in 2019.

- PHP reports that their membership significantly increased from December 2017 to September 2018 by 77,322 members or +37.2%. In September 2018 PHP entered into an agreement with UHC to transition approximately 70,000 members to PHP. Throughout this transition HSD monitored care coordination to ensure all vulnerable members received continuous care. PHP is contracted with approximately 7,429 providers and practitioners including hospitals and additional facilities and ancillary service providers.

- UHC was released from NM Medicaid contracts as a result of an arrangement to transition members to PHP. From December of 2017 to August of 2018 UHC member enrollment remained stable with decrease of 1,257 or 1.8%. Throughout this transition HSD monitored care coordination to ensure all vulnerable members received continuous care. UHC has 2,452 contracted Medicaid agreements with PCPs and 3,675 contracted Medicaid agreements with specialists throughout New Mexico and its bordering states. In addition to PCPs, UHC has contracted Medicaid agreements with 17 Federally Qualified Healthcare Centers (FQHCs) and 9 Rural Healthcare Centers (RHCs), 42 hospitals of various types, and 303 pharmacies throughout the State of New Mexico.

See Section II. for additional information on provider access.

Summary of Outcomes of Reviews and Focused Studies

Service Plan Reductions Audit

HSD continues to review a sample of service plan reductions for members who previously had HCBS services under a section 1915(c) waiver and continued to meet the NFLOC criteria upon transition to the 1115 waiver, Centennial Care in 2014. HSD selected a random sample of 30 charts from BCBS, MHC, and PHP to review. UHC only identified 6 members in their universe and all 6 member charts were selected for review.

BCBS audits revealed the reduction in PCS hours in 29 of the 30 files were appropriate and included documentation to support member improvement, increases in natural supports and shared households. HSD sought additional information for the remaining member file and BCBS provided the requested clarification. Per BCBS, the member's PCS hours did not address time for Supportive Mobility Assistance. BCBS arranged for a re-assessment to address member's ability to perform ADLs and ensure that they are correctly entered on the Allocation tool before submission to Utilization Management (UM). Individual coaching on this case was not provided as the reviewer is no longer with BCBS; however, BCBS notes that a review has been provided to the UM team regarding performance of a double-check to ensure that allocations are both appropriately aligned with the Care Coordinator's assessment and correctly represented on the PCS Allocation Tool.

MHC audits revealed the reduction in PCS hours in 22 of the 30 files were appropriate and included documentation supporting member improvement, increases in natural supports or shared households. MHC also had 6 audit files which did not reveal a reduction in PCS hours.

HSD sought clarification for the 2 remaining files, which lacked documentation necessary to review the reduction decision. For one of the files, MHC provided the requested CNA which indicated improvement in ADLs. For the other member file, MHC sent the requested documentation, an Allocation Tool completed in 2016; however, MHC was unable to provide justification for PCS reduction for this member from 38 to 30 hours per week. MHC is no longer a contracted MCO therefore HSD did not provide direction or technical assistance to MHC regarding appropriate allocation of PCS hours.

PHP provided 30 member charts for review and the audit revealed that 28 of the 30 were appropriate and included documentation supporting member improvement, increases in natural supports and shared households. The 2 remaining member charts did not reveal a reduction in PCS hours.

UHC submitted 6 files for review. For 5 of the files, the reduction was related to member improvement, increased natural supports, or shared living space. The remaining audit file did not have documentation justifying the reduction in PCS hours from 47 to 32.75. UHC is no longer a contracted MCO therefore HSD did not provide direction or technical assistance to UHC regarding appropriate allocation of PCS hours.

HSD will continue to monitor the MCOs and direct to continue staff training on clear, concise, and comprehensive documentation for member records.

Table 17 – DY5 Service Plan Reduction

Service Plan Reduction	BCBS	PHP	Molina	UHC
Number of member files audited	**30**	**30**	**30**	**6**
Number of files with inappropriate reduction	1	0	1	1
Number of files with no reduction or increase	0	2	6	0
Number of files which showed an increase	0	0	0	0
Number of files with appropriate reduction	29	28	23	5

Myers & Stauffer Evaluation

In DY 5, HSD contracted with Myers and Stauffer to conduct an audit of NF claims adjudicated for the period of July 2016 through June 2017. MCOs were given an opportunity to review the draft report and offer additional documents and feedback. The final report included findings and recommendations for changes to MCO policies and procedures that were not compliant or only partially compliant with contract requirements, the Managed Care Policy Manual, the MCO Systems Manual and/or the New Mexico Administrative Code. HSD continues to monitor the MCOs to ensure polices are updated and implemented.

Summary of Performance Improvement Projects

In DY4 HSD required each MCO to implement four (4) Performance Improvement Projects (PIPs). The MCOs are guided to develop the PIPs in accordance with CMS, External Quality Review (EQR) protocol 3. The MCOs were encouraged to design the PIPs to target relevant clinical or non-clinical services specific to member needs. The MCO aim for each PIP is to meet the unique needs of the members, to ensure sustainable improvements and interventions, and to focus on quality improvement.

Pursuant to the Centennial Care Contract, two (2) PIPs focused on the following areas: one (1) Services to Children; and one (1) Long Term Care Services. For these PIPs the MCOs were given the opportunity to select their individual study groups and study indicators relevant to the service areas identified.

In addition, HSD directed the MCOs to develop two (2) PIPs relevant to disease management with prescribed indicators as detailed below:

Prevention and enhanced disease management for diabetes;

- Short-term complications admission rate
- Hemoglobin A1c testing

Screening and management for clinical depression;

- Antidepressant medication management
- Screening for clinical depression and follow-up plan

On July 1, 2018 HSD contracted with Island Peer Review Organization (IPRO) to perform as the External Quality Review Organization (EQRO) for New Mexico. IPRO is currently conducting the CY 17 PIP validation and has provided preliminary results. Validation activities are completed in accordance with EQR Protocol 3, as required by CMS, which details the process that is used to assess the validity and reliability of the PIPs developed by the MCOs.

CMS-Defined 10 Step Process for Validating PIPs	
1. Review the study topic	6. Review data collection procedures
2. Review the study question	7. Review data analysis and interpretation of study results
3. Review identified study population	8. Assess the MCOs improvement strategies
4. Review indicators	9. Assess the likelihood that reported improvement is "real" improvement
5. Review sampling methods	10. Assess sustainability of the documented improvements.

The table below represents the MCO PIPs for CY 17.

MCO	**Children's Services (PIP #1)**	**Long-Term Services and Supports (PIP #2)**	**Diabetes Management and Prevention (PIP #3)**	**Clinical Depression Screening and Follow-up (PIP #4)**
BCBS				
PIP-	Attention to Dental Health for Children	Diabetic Eye Exams	Short-Term Complications Admissions Rates HbA1c testing	Screening and Management for Clinical Depression
MHC				
PIP-	BMI percentile, nutrition, physical activity ages 3-17	Fall Risk Factors and Service Referrals for LTSS	Diabetes Prevention and Management	Clinical Depression Screening and Follow Up
PHP				
PIP-	Adolescent Well-Care Visit	Inter-Rater Reliability for Personal Care Services allocation	Diabetes Prevention and Management	Screening and Management of Clinical Depression

UHC				
PIP-	Increasing Annual Pediatric Dental Visits	Influenza Vaccination for Long Term Care (LTC) Population	Diabetes Prevention and Enhanced Disease Management	Antidepressant Medication Management

The goal of a PIP is to attain sustainability of the initiatives introduced to achieve the desired outcomes. The effectiveness of the interventions implemented by the MCO are measured through the analysis of target indicators against the established baseline.

The following is a summary of each MCO's PIPs for CY 17, which includes the aims, interventions and conclusions drawn from the data submitted for each PIP.

Blue Cross Blue Shield (BCBS)

PIP #1- Attention to Dental Health for Children: This PIP focused on dental health as a vital element of children's overall well-being; i.e., annual dental visits for members who are 2 to 20 years of age. A continuous enrollment of 12 months was specified for inclusion. No more than one gap in enrollment of up to 45 days during the measurement year was permitted. Interventions include; annual dental visit postcard mailings; sharing of educational scripts during one-on-one discussions with members or guardians of members; member outreach providing basic education on the necessity of completing their annual dental visit; Centennial Rewards program incentives; and assisting members with scheduling dental visits and providing transportation to those scheduled visits.

Annual Preventive Dental Visits			
CY 14	**CY 15**	**CY 16**	**CY 17**
59.18%	59.83%	61.78%	64.38%

Conclusions:
Interventions implemented by BCBS from CY 14 through CY 17 to increase annual dental visits in children 2 to 20 years of age had a positive increase of 5.2 percentage points. In review of the 4-year PIP implementation, this PIP shows effective improvement with respect to BCBS's goals.

PIP #2 - Long-Term Care: Diabetic Eye Exams: This PIP focused on improving the rate of diabetic LTSS members who received screening for diabetic retinopathy. Interventions included; creating gap lists that identified members with diabetes who needed a diabetic eye exam; mailed provider letters to long-term care (LTC) facilities to advise of gaps in care information for 184 diabetic members; telephonic outreach to LTC Facilities and diabetic educational materials for long-term care members that focused on retinal eye exams and included BCBS clinical practice guidelines for diabetes.

Diabetic Eye Exams			
CY 14	**CY 15**	**CY 16**	**CY 17**
8.90%	20.35%	22.76%	20.50%

Conclusions:
Interventions were impactful when compared to the CY 14 baseline measurement. Although CY 17 experienced a decline of 2.26 percentage points, this result maintains an 11.6 percentage point increase above the baseline year. Year-over-year results show a positive effect supporting the aims of this PIP.

PIP #3 - Diabetes Prevention and Enhanced Disease Management: The Diabetes Prevention and Enhanced Disease Management PIP focused on BCBS adult members with a diagnosis of diabetes with a focus on the two required indicators, HbA1c testing and admissions for short-term complications related to their condition. The study population included members admitted to the hospital due to diabetes-related complications. BCBS interventions for CY 17 included mailings to members diagnosed with diabetes who have one or more Comprehensive Diabetic Care (CDC) gaps in care (A1c, Diabetic Nephropathy, Diabetic Retinopathy screenings) that remain uncompleted.

HbA1c testing			
CY 14	**CY 15**	**CY 16**	**CY 17**
83.42%	80.43%	82.56%	82.00%
Hospital Admissions/Diabetes (rate per 100,000-member months)			
CY 14	**CY 15**	**CY 16**	**CY 17**
23.35	22.16	17.93	18.98

Conclusions:
Data collected demonstrates the interventions applied towards increasing HbA1c testing were not impactful and reflect a decrease of 1.42 percentage points from CY 14 to CY 17. The data did indicate a favorable decline in admissions rates of 4.37 admissions per 100,000-member months from baseline year of CY 14 to present reporting period of CY 17. This is indicative of effective interventions developed and implemented by BCBS for reducing admissions.

PIP #4 – Screening and Management for Clinical Depression: This PIP focused on screening for clinical depression and medication management for members 18 and older. The target goal for antidepressant medication management consists of a 2% improvement over 2016 outcomes, while the target goal for depression screening consists of a 10% increase over 2016 outcomes of members who completed routine appointments. Interventions included engaging members telephonically to encourage and offer assistance with refilling antidepressant medications; a provider incentive program that rewards providers financially for noting the outcome of a depression screening as positive or negative, as well as developing a care plan; and a pilot call campaign to providers to promote depression screening incentives.

Screening for Clinical Depression (18-64 years of age)		
CY 15	**CY 16**	**CY 17**
0.36%	0.49%	0.77%
Screening for Clinical Depression (65+ years of age)		
CY 15	**CY 16**	**CY 17**
4.55%	2.37%	3.45%
Antidepressant Medication Management Acute (18-64 years of age)		
CY 16	**CY 17**	
50.63%	45.54%	
Antidepressant Medication Management Acute (65+ years of age)		
CY 16	**CY 17**	
47.17%	60.00%	
Antidepressant Medication Management Continuous (18-64 years of age)		
CY 16	**CY 17**	
34.54%	30.83%	
Antidepressant Medication Management Continuous (65+ years of age)		
CY 16	**CY 17**	
32.08%	53.33%	

Conclusions:

Data reported for this PIP reflects a positive upward trend over the last 3 years. This indicates that the interventions applied are producing the desired results of increasing the number of Screenings for Clinical Depression. BCBS reports CY 16 as the baseline year for the second indicator, Antidepressant Medication Management. Second year reporting reflects that the applied interventions had a positive impact upon members 65 years and older for both the acute and continuous phases of medication management.

Molina Health Care (MHC)

PIP #1 -Services to Children: Body Mass Index, (BMI), Percentile, Nutrition, Physical Activity Ages 3-17: The purpose of this PIP is to improve physician documentation of Well-Child Check, (WCC), Body Mass Index (BMI), physical activity counseling, and nutrition counseling HEDIS scores. This PIP focused on creating a provider-level intervention for improving administrative rates for the WCC subcomponents. Initiatives developed to support this PIP included identification of high-volume pediatric providers; provider education and training with respect to appropriate coding to meet the reporting requirements of the WCC; and assessment of administrative WCC rates at year-end in comparison to the following indicators: Prior year rates in their own practices; and Provider practices who had not participated in the interventions.

Improvement of Well-Child Check Measures	**CY 16** (Baseline year)	**CY 17**
Body Mass Index (BMI)	7.79%	11.01%
Counseling for Nutrition	3.82%	4.05%
Counseling for Physical Activity	2.95%	3.11%

Conclusions:
This PIP was introduced in CY 16 which as the baseline year. The data submitted by MHC indicates that interventions implemented for this PIP are producing positive outcome with all three sub-components. BMI with a 3.22 percentage point increase had the largest increase measure. Counseling for Nutrition increased by 0.23 percentage points and Counseling for Physical Activity measures increased by 0.16 percentage points.

PIP #2 – Fall Risk Factors and Service Referrals for LTSS. The target goal for this PIP was a 10% decrease in fall events within the LTSS member population from 2016 to 2017. Interventions included an online self-paced training for care coordinators. MHC developed training materials for care coordinators by applying information obtained through data analysis of the MHC members receiving LTSS services, and by utilizing external research on fall risks in the LTSS populations.

Members with Falls			
CY 14	**CY 15**	**CY 16**	**CY 17**
18.47%	24.13%	26.38%	23.33%

Conclusions:
Reported data indicates a steady increase in fall events from CY 14 to CY 16. The training intervention was implemented in June 2017 attributing to the decrease of 3.05 percentage points. This indicates that the intervention is producing positive outcomes on reducing falls among LTSS members.

PIP #3 – Diabetes Prevention and Management: This PIP focused on diabetes management, HbA1c testing and reducing diabetes short-term complications admissions. The goal was to observe a 2% increase in the number of members with HbA1c tests, and a 2% decrease in the number of hospital admissions for specific diabetes-related complications. Interventions implemented by MHC included: creation of provider toolkits and tip sheets; updates and improvements to provider lists made through a corporate data enhancement project; and member education and health promotion activities, including health fairs.

HbA1c Testing			
CY 14	**CY 15**	**CY 16**	**CY 17**
73.78%	77.03%	77.61%	76.84%
Hospital Admissions/Diabetes (rate per 100,000-member months)			
14.81	9.75	11.8	9.27

Conclusions:
Data submitted reflects HbA1c testing increased 3.06 percentage points from CY 14 to CY 17. Admissions rates show a favorable decrease of 5.54 admissions per 100,000-member months from CY 14 to CY 17 indicating interventions are producing positive results in reducing admissions related to complications.

PIP #4 – Clinical Depression Screening and Follow Up: The focus of this PIP aims to use a patient-centric coaching model coupled with care coordination to improve antidepressant medication adherence as measured by claims data using the HEDIS Antidepressant Medication Management (AMM), – Effective Acute Phase Treatment and Effective Continuation Phase Treatment specifications. Interventions include outreach to providers for proper medication management strategies; outreach to providers regarding medication adherence improvement strategies; and encouragement of providers to utilize proper coding for depression screening and follow up plans on claims to capture the data administratively.

Screening for Clinical Depression			
CY 14	**CY 15**	**CY 16**	**CY 17**
0.01%	0.06%	0.07%	0.16%
Antidepressant Medication Management Acute Phase			
CY 14	**CY 15**	**CY 16**	**CY 17**
53.50%	49.56%	47.19%	45.77%
Antidepressant Medication Management Continuation Phase			
CY 14	**CY 15**	**CY 16**	**CY 17**
38.63%	34.67%	32.11%	32.13%

Conclusions:
Screening for clinical depression demonstrates a gradual upward trend. Data reported indicates an increase in screenings for clinical depression of 0.15 percentage points from CY 14 to CY 17. Data reported for Antidepressant Medication Management indicates the interventions applied are not achieving the desired outcomes of improving member adherence with prescribed treatments for depression. The Acute Phase Treatment experienced a 7.73 percentage point decrease from CY 14 to CY 17, and a 6.5 percentage point decrease from CY 14 to CY 17 was noted for the Continuation Phase Treatment.

Presbyterian Health Plan (PHP)

PIP #1- Services to Children- Adolescent Well-Care (AWC) Visit: This PIP was created with the intention of improving well care for the adolescent target group by assisting in prevention of physical and behavioral health conditions, monitoring and tracking developmental milestones, and early identification of disease processes. The measurement of success includes a two percent increase in the completion of an AWC according to the HEDIS technical specifications. The age range for AWC is 12-21 years. The target group consisted of members who meet the AWC HEDIS Technical Specification measure criteria and who are assigned to a provider who is currently a participating provider contracted with PHP. Interventions included introduction of the AWC HEDIS measure into the Provider Quality Incentive Program (PQIP) comprised of 96 provider groups; quarterly training by Quality for Provider Network Management; outbound calls by Provider Network Management to the PQIP to identify opportunities and barriers.

Adolescent Well-Care Visit for Adolescents Ages 12-21 Years
CY 17 (baseline year)
19.9%

Conclusions:
This PIP was introduced in CY 17 and the data reported will be considered the baseline.

PIP #2 – Long-Term Services and Supports. Inter-Rater Reliability for Personal Care Services Allocation: This PIP focused on implementation of the Personal Care Services (PCS) allocation tool by PHP care coordinators. The PIP was introduced in CY 14 and has increased consistency of the allocation of PCS hours by PHP Staff. The goal for CY 17 is to maintain or improve the CY 16 reported result. PHP interventions include review of 2016 testing and results; provision of education to staff to ensure appropriate administration of the tool; review of the supplemental assessment to include a NFLOC; and staff to complete inter-rater reliability testing; and one-on-one coaching with staff who submitted outlier hours.

Inter-Rater Reliability for Personal Care Services Allocation (LTSS)			
CY 14	**CY 15**	**CY 16**	**CY 17**
93.00%	99.40%	99.70%	99.80%

Conclusions:
The intervention applied by PHP have produced positive outcomes. The data reported indicates an upward trend in accuracy and consistency in the assessment used to approve the number of hours allocated for PCS. The PIP performance has improved 6.8 percentage points from CY 14 to CY 17.

PIP #3 – Diabetes Prevention and Management: This PIP focused on reducing diabetes short-term complications admissions rates and improving rates of HbA1c testing. The study population were members who met the HEDIS Comprehensive Diabetes Care and HbA1c sub measure sample denominator of 548. Members in hospice are excluded from the eligible population. Interventions include screening events; on-the-spot testing rewards; rewards for participating in Healthy Solution health coaching; disease management outreach; and member newsletter articles.

HbA1c Testing		
CY 15	**CY 16**	**CY 17**
86.64%	83.25%	84.85%
Hospital Admissions Diabetes Short Term Complications (18-64 years of age)		
CY 15	**CY 16**	**CY 17**
14.56	11.81	12.37
Hospital Admissions Diabetes Short Term Complications (65+ years of age)		
CY 15	**CY 16**	**CY 17**
37.11	11.14	11.70

Conclusions:
Data reported by PHP indicates the interventions applied by PHP reflect a positive increase of 1.6 percentage points from CY 16 to CY 17 for HbA1c. PHP also reported a significant decrease of 25.41 admissions per 100,000-member months of member 65+ years of age and a decrease of 2.19 in admissions per 100,000-member months of members 18-64 years of age who experienced a short-term complication due to their condition, which indicate the interventions applied are reducing admissions related to diabetes short-term complications.

PIP #4 – Screening and Management for Clinical Depression: The focus of this PIP was to improve the rates of screening for clinical depression and to improve the member's adherence to antidepressant medication for members 18 and over. Interventions implemented by PHP to support this PIP include conducting member outreach via outbound reminder calls; increased contact with members by a BH care coordinator; referral to providers for treatment; and written educational materials sent to members and/or nurse outreach.

Screening for Clinical Depression (18-64 years of age)		
CY 17 (baseline)		
15.04%		
Screening for Clinical Depression (65+ years of age)		
CY 17 (baseline)		
22.72%		
Medication Management Acute (18-64 years of age)		
CY 15	**CY 16**	**CY 17**
53.35%	51.88%	50.59%
Medication Management Continuous (65+ years of age)		
CY 15	**CY 16**	**CY 17**
36.24%	35.55%	34.31%

Conclusions:
PHP reports data collected in CY 17 as the baseline for clinical depression indicator for this PIP. Data reported by PHP reflects a downward trend in both the acute and continuous phase of medication management for depression. Interventions applied by PHP are not having a positive impact on this indicator.

United Health Care (UHC)

PIP #1- Increasing Annual Pediatric Dental Visits: This PIP was introduced in CY 14 with a focus the effectiveness of targeted outreach to members and providers on rates of members ages 2 to 20 years of age. Data for dental utilization was annually monitored through program pull of claims and encounters. UHC staff utilizes QSI/QSHR software to analyze the data. Additionally, UHC worked in collaboration with other MCOs and HSD to obtain usable "behavioral" data from the Centennial Care Rewards initiative, specific to dental behaviors. Interventions for this PIP include; education on, and training for care coordinators regarding dental benefits available to member populations; promotion of dental visits during health assessments; annual mailings that highlight/promote dental visit benefits; and Wal-Mart gift cards provided to members who completed their annual dental visits.

Preventive Dental Visits (less than 21 years of age)			
CY 14	**CY 15**	**CY 16**	**CY 17**
41.52%	49.88%	53.93%	61.02%

Conclusions:
Interventions implemented by UHC have produced positive outcomes in increasing the number of dental visits for members in the target group. Data provided by UHC reflects a consistent year over year increase in dental visits and a significant increase of 19.5 percentage points from CY 14 to CY 17.

PIP #2- Influenza vaccinations for LTSS members: The aim of this PIP is to increase seasonal flu vaccinations for the LTSS population as a quality measurement and improvement initiative. This PIP focused on a vulnerable population that was at a higher risk of serious illness or death from influenza or complications of influenza. The target age group for program recipients is 18-64 years and 65+. Interventions for this PIP include; training for care coordination staff to understand the importance of promoting the influenza vaccination to high-risk members; a tool developed to outline talking points to promote vaccination for the flu as well address any misconceptions regarding risks; education and promotion of the vaccination during routine contacts scheduled as soon as the vaccination is available; and member newsletter articles regarding the importance of flu vaccinations.

Influenza Vaccination for LTSS Members (18-64 years of age)
CY 17 (baseline year)
46.00%
Influenza Vaccination for LTSS Members (65+ years of age)
CY 17 (baseline year)
63.40%

Conclusions:
This PIP was introduced as a new PIP for CY 17. UHC noted the baseline as 46% members 18-64 years of age, and 63.40% percent for 65+ years of age. Data collected by UHC indicated that the baseline measurement period occurred October 1, 2016 through May 31, 2017.

PIP #3 - Diabetes Prevention and Enhanced Disease Management: This PIP focused on reducing diabetes short-term complications admissions rates and on improving rates of HbA1c testing. The PIP also aimed to identify the number of discharges for diabetes short-term complications per 100,000 Medicaid enrollees age 18-64 and age 65 and older; decrease the admission rates for short-term diabetes complications by 2 percentage points over a one-year period; and to use claims data to determine the percentage of members age 18-64 and age 65-75 who had a diagnosis of Diabetes Mellitus (type 1 and type 2) and who had an HbA1c test. UHC also aimed to increase the percent of members who received A1c testing by 2 percentage points over a one-year period. Interventions for this PIP include collaborations with other MCOs to develop one-page practice guideline handouts to providers; provide outreach to providers on members identified with gaps in care; utilization of mobile units to provide HbA1C testing; and offers of enrollment to members in the diabetes targeted health management program.

HbA1c Testing			
CY 14	**CY 15**	**CY 16**	**CY 17**
51.44%	56.32%	60.65%	87.75%
Hospital Admissions Due to Complication from Diabetes (18-64 years of age)			
CY 14	**CY 15**	**CY 16**	**CY 17**
38.35%	33.42%	37.50%	21.60%
Hospital Admissions Due to Complication from Diabetes (65+ years of age)			
CY 14	**CY 15**	**CY 16**	**CY 17**
98.80%	270.89%	150.80%	24.70%

Conclusions:
UHC data indicates interventions applied for the HbA1c testing indicator had a significant impact on increasing the number of members completing HbA1c testing by 36.31 percentage point from CY 14 to CY 17. UHC also reports a favorable decrease of 4.85 percentage points from CY 14 to CY 17 in the number of admissions attributed to diabetes short-term complications. This indicates the interventions applied for this indicator are producing the expected positive outcome.

PIP #4 – Antidepressant Medication Management, Screening for Clinical Depression and Compliance: The focus of this PIP was to improve the compliance of standards of care regarding screening for depression for adults. The Plan included all UHC members ages 18-64 for determining the rate of the adult members receiving a screening for clinical depression using a standardized tool with a follow up plan, as well the percentage of adult members with a diagnosis of major depression that were newly treated with antidepressant medication and remained on antidepressant medication treatment. Interventions for this PIP include community outreach events that educate and raise awareness; Behavioral Health Recovery and Resilience team outreach to member groups; provider educational outreach on depression and provider and member newsletters.

Screening for Clinical Depression			
CY 14	**CY 15**	**CY 16**	**CY 17**
0.93%	0.01%	0.02%	0.01%
Antidepressant Medication Management Acute Phase			
CY 14	**CY 15**	**CY 16**	**CY 17**
62.50%	56.62%	53.16%	52.32%
Antidepressant Medication Management Continuation Phase			
CY 14	**CY 15**	**CY 16**	**CY 17**
48.34%	42.89%	38.97%	37.48%

Conclusions:
Data submitted by UHC did not reflect improvements in Screening for Clinical Depression. Reported metrics reflect a decline from CY 14 to CY 17. Medication management for both phases reflects a decline of 10.18 percentage points for the Acute phase and 10.86 percentage points for the Continuation phase from CY 14 to CY 17. Interventions applied for this PIP for both indicators did not have a positive impact.

Outcomes of Performance Measure Monitoring

HSD included eight (8) performance measures (PMs) with assigned performance targets in the Centennial Care contract for CY 17 and CY 18. All PMs, with the exception of PM 8, are based on the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) technical specifications for the current reporting year. PM 6, *Frequency of Ongoing Prenatal Care*, was retired as a HEDIS measure at the end of 2017 and has since been removed as a PM.

- PM 1 - Annual Dental Visits
- PM 2 - Medication Management
- PM 3 - Controlling High Blood Pressure
- PM 4 - Comprehensive Diabetes Care
- PM 5 - Timeliness for Prenatal and Postpartum Care
- PM 6 - Frequency of Ongoing Prenatal Care (removed)
- PM 7 - Antidepressant Medication Management
- PM 8 - Follow-up After Hospitalization for Mental Illness

PM targets are based on NCQA's Quality Compass (QC), Health and Human Services (HHS) Dallas regional averages for the current reporting year. The MCOs are required to meet; a two (2) percentage point improvement above the previous year's reported HEDIS rate or HSD's established target, or the HHS regional average reported by QC.

The annual validation of PMs for CY 17 is currently under review by the EQRO. The validation is conducted and reported as a mandatory EQR activity in accordance with CMS EQR Protocol 2, which defines the activities and tools necessary to access the accuracy of PMs reported by each MCO.

The chart below represents the aggregated total of each performance measure based upon the MCOs audited HEDIS rates from CY 14 through CY 17. To view the complete MCOs HEDIS results please visit http://www.hsd.state.nm.us/LookingForInformation/healthcare-effectiveness-data-and-information-set.aspx.

Conclusions:

A review of the MCO audited HEDIS reports, and the preliminary findings of the EQRO's PM validations for CY 17 provide the following information the for CY 17, with comparisons made against the HHS regional averages.

PM 1 – Annual Dental Visits: Reported rates improved for all MCOs from CY 16 to CY 17. All MCOs performed above the previous years HEDIS rates for Annual Dental Visits, and two (2) MCOs exceeded the HHS regional average.

PM 2 – Medication Management for People with Asthma: Three of the four MCOs improved performance from CY 16 to CY 17. None of the MCO exceeded the HSD established target of 68%.

PM 3 – Controlling High Blood Pressure: One of the four MCOs reported improvement from CY 16 to CY 17 and all four (4) MCOs exceeded the HHS regional average of 44.85% for CY 17.

PM 4 – Comprehensive Diabetes Care: Three of the four MCOs reported improved performance from CY 16 to CY 17 in diabetic eye exams and all but one MCO met or exceeded the HHS regional average of 52.09%. Three of the four MCO met or exceeded CY 16 reported rates for HbA1c testing. All four MCO reported declines from CY 16 in reported rates nephropathy testing. Two of the four MCOs reported positive reporting with declines from CY 16 in HbA1c poor control.

PM 5 – Timeliness for Prenatal and Post-partum Care: Two of the four MCOs reported positive improvements from CY 16 to CY 17 for Prenatal Care and one MCO reported improved rates in Post-Partum Visits.

PM 6 – Frequency of ongoing Prenatal Care: Not reported for CY 17, measure retired by HEDIS.

PM 7 – Antidepressant Medication Management: All four MCOs did not meet the performance targets set for this measure.

PM 8 – Follow-up after hospitalization for Mental Illness: This PM was previously reported based on HEDIS technical specifications but was modified in CY 17 and is pending EQRO validation of metrics reported by the MCO.

Summary of Plan Financial Performance

Overview

HSD continues to monitor managed care organization (MCO) contractual compliance for insolvency and performance bond coverage. All MCOs remained in good standing by maintaining an account balance equal to no less than ninety percent (90%) of the average monthly capitation paid to the MCO in the fourth quarter of calendar year (CY) 2018. Also, the MCOs remained compliant with Fidelity bond requirements. To limit the MCOs' risk of catastrophic losses and its exposure to large claims by individuals with chronic or high cost conditions, the MCOs maintained a minimum of one-million dollars ($1,000,000) per member in reinsurance protection. The reinsurance pays a percentage of losses in excess of the deductible; twenty (20) members met the reinsurance deductible in CY 2018.

HSD has provisions in the Centennial Care contract which allow for recoupment of capitation payments made for members who were incorrectly enrolled with more than one MCO, passed away prior to the enrollment month, or were Medicaid ineligible members on ex post determination. HSD also processes mass adjustments for capitation payments issued at a non-dual rate cohort and then reissued at a dual rate cohort for members who are retroactively determined to have Medicare coverage and do not exceed the time period that the MCO can retroactively adjust claims payment to providers for those services for which Medicare would be the primary payer. The recoupments and adjustments are processed monthly. In CY 2018, HSD began to recoup capitation payments for individuals who have their benefits suspended after 30 days of incarceration.

The reconciliations for retroactive eligibility period, patient liability, Hepatitis C, and risk corridor for CY 2016 were finalized and processed during CY 2018. HSD implemented a risk corridor for the Group VIII (Medicaid expansion) population to account for the uncertainty and variability of medical utilization and costs during the first three years of implementing the Affordable Care Act under the Centennial Care contract. CY 2016 was the third year of using the risk corridor and the reconciliation has been finalized. Prorated payments or recoupments related to CY 2017 capitation payments were also made; final reconciliations for CY 2017 will be completed in CY 2019.

After finalizing the reconciliations mentioned above, the reconciliation of underwriting gain earned by each MCO for CY 2016 was performed. One MCO exceeded the permitted three percent (3%) underwriting gain limitation. Per contractual agreement, that MCO must return fifty percent (50%) of the underwriting gain in excess of three percent (3%) to HSD. A recoupment for $14.4 million was processed.

During the third quarter of CY 2018, United Health Care Community Plan (UHC) terminated its participation in the Centennial Care Medicaid program when Presbyterian Health Plan (PHP) bought out Medicaid members from UHC. On September 1, 2018, UHC transitioned approximately 86,000 members to PHP. UHC will continue to submit all required financial reports for 2018 and HSD will continue to work with UHC as necessary through the run-out period for financial reporting.

All MCOs submitted their financial reports for the fourth quarter of CY 2018 on February 15, 2019. Those reports have been reviewed and significant variances have been communicated to the MCOs for further review and explanations. HSD continues to focus attention on categorization of expenditures by program, cohort, and category of service along with comparisons between encounter data and financial reports. The CY 2018 annual supplement financial reports are due on May 15, 2019. In addition to reviewing the financial reports, HSD continues to monitor and evaluate the financial and operational performance of the MCOs.

Status and Results

In CY 2018, HSD finalized the financial reconciliations and risk corridor evaluations for the CY 2016 contract period. The results of the financial reconciliations and risk corridor evaluations are reflected in the underwriting gain calculation as either increases or reductions to capitation revenue. For CY 2016, one of the four MCOs exceeded the three percent (3%) underwriting gain limitation and recoupments have been processed for the amount owed to HSD and reflected in the financial results. In CY 2018, initial evaluations for the CY 2017 contract period were completed and the final results are scheduled to be completed and processed by the end of CY 2019.

Since encounter data expenditures are one of the main sources of information used in the reconciliation and risk corridor determinations, HSD continues to work closely with the MCOs to ensure encounters are submitted in a timely and accurate manner. HSD continues to see improvement in encounter submissions.

All MCOs submitted their CY 2018 fourth quarter financial reports on February 15, 2019. Those reports have been reviewed and significant variances have been communicated to the MCOs for further review and explanation. MCOs are required to submit the CY 2018 annual supplement financial reports on May 15, 2019. HSD monitors MCO contractual compliance for insolvency, reinsurance, and fidelity and performance bond coverage utilizing the financial reports submitted. In the analysis of the financial reporting packages, HSD evaluates the MCOs financial and operational performance at both the individual MCO level and an aggregate level. HSD continues to focus attention on the categorization of expenditures by program, cohort and category of service. Comparison of reported encounter data to financial data also continues to be a focus in the analysis of financial reports.

SECTION VI: SUMMARY OF QUALITY OF CARE/HEALTH OUTCOMES FOR AI/AN BENEFICIARIES

During DY5, data indicated that all MCOs had increases in specialty care visits for Native Americans psychotherapy, ophthalmology, orthopedic, cardiology, nephrology, and podiatry. All Centennial Care MCOs continued to work on the numbers of HRAs completed in 2018 for Native Americans and are partnering with Tribal organizations to enhance care coordination services to their members. The MCOs continue to increase attendance at their Native American Advisory Board (NAAB) meetings and extend invitations to Tribal leadership, Indian Health Service and community providers to address issues related to benefits, access and delivery of services, and other concerns specifically related to Native American enrollees.

In addition, three of the four MCOs saw decreased medical admission rates ranging from 30% to 53% for Native Americans.

The following chart outlines the top five Community Benefits utilized during calendar year 2018:

Table 18 – Highest Utilized Community Benefit Services by Native Americans

Rank	Procedure Code Description
1	Personal Care (per hour)
2	Emergency Response (month)
3	Homemaker (hourly)
4	Respite (hourly)
5	Assisted Living (month)
6	Related Goods
7	Environmental Modifications (project)
8	Skilled Maintenance Therapies (hourly)
9	Customized Community Supports
10	Community Transition Services (service)

For BH services in frontier areas, all four MCOs met the access to services targets at 96.8 percent. For PH services, all four MCOs met access to care by 97 percent or more in frontier areas.

In the fifth waiver year the most popular Value Added Services (VAS) requested by Native American members included traditional healing benefits, full coverage Medicaid for pregnant women, followed by wellness centers, and sports physicals for youth.

HSD will continue to monitor health outcomes for Native American Centennial Care members through enhanced reporting from the MCOs in the next waiver year.

A. Native American Advisory Meetings

In 2012 Centennial Care established the Native American Technical Advisory Committee (NATAC), a subcommittee of the Medicaid Advisory Committee comprised of Tribal leaders, and/or appointed tribal representatives, IHS, Tribal 638 clinics, and state leadership, to:

- Promote a stronger government-to-government relationship, comprised of positive communication and respect, trust, accountability, and shared responsibility;
- Continue discussion regarding Medicaid, including Centennial Care 2.0 and the 1115 Waiver; and
- Continue discussions regarding implementation of the CMS guidance regarding services "received through an IHS facility".

B. 100% FMAP for Services Received through an IHS/Tribal 638 Facility

Albuquerque Area IHS (AAIHS) and UNMH

UNMH continues to bill for the FMAP for Fee for Service (FFS) members as well as Native Americans enrolled with a MCO referred by IHS.

Navajo Area IHS (NAIHS) and UNMH

The Care Coordination Agreement (CCA) between UNMH and Navajo Area IHS was signed 09/26/2018. UNMH began billing for claims 12/01/2018 after a system configuration that was required to process identified claims for the 100% federal match with NAIHS.

AAIHS and Presbyterian (PHS)

Presbyterian began claiming the FMAP for services referred by IHS 05/01/2018. Currently they are only identifying claims for FFS members and continue to discuss capturing the FMAP for Native Americans enrolled with a MCO.

NAIHS and Presbyterian (PHS)

The CCA discussions were delayed due to the federal shutdown since key players with NAIHS were unable to be on the calls. Our first conference call between NAIHS and Presbyterian was 01/30/2019. Presbyterian has asked NAIHS to research the volume of referrals NAIHS is sending to Presbyterian providers before a second meeting is scheduled. A follow up meeting is scheduled for 3/20/2019 to discuss billing the FMAP on Native Americans in FFS that go to PHS for follow up.

Table 19 – Schedule of DY5 NAAB Meetings

MCO	Location/Date of Board Meeting	Issues/Recommendations
Quarter 4 - 2018		
BCBS	PMS Farmington Community Health Center Farmington, New Mexico October 17, 2018	**Issue:** A member asked the difference between home health services and personal care services. **Response:** BCBS stated home health services are for short term acute conditions. Personal Care Services (PCS) are for chronic conditions requiring long-term care. A member needs to qualify for PCS based on Activities of Daily Living (ADL).
Molina	Five Sandoval Indian Pueblos, Inc. Rio Rancho, New Mexico September 12, 2018	There have been some changes to the Motherhood Matters program. One major change Molina informed the group about is a $20 Walmart gift card in lieu of a car seat upon completion of the program. **Issue:** What is the difference between an emergency room (ER) visit and an urgent care visit? **Response:** Molina provided examples of the difference and explained when each one should be used. **Issue:** What is the status of Molina Healthcare in 2019? **Response:** Molina informed members that Molina Healthcare was not selected to be an MCO for Centennial Care 2.0 starting January 1, 2019. Molina Healthcare will continue to provide Medicaid coverage until the end of 2018.
PHP	CHR Conference Room Mescalero, New Mexico October 19, 2018	**Issue:** A lot of members don't know anything about care coordination. **Response:** PHP had care coordinators at the meeting who explained what care coordination is and how care coordinators can help you. It starts with a health risk assessment. **Issue:** PHP's transportation vendor, SMT, does not offer mileage reimbursement. SMT denied member transportation because they needed to find a doctor closer to Ruidoso. **Response:** SMT does not approve or deny transportation. If the travel distance is exceeded, then SMT reaches out to the PHP travel team to give a determination. **Issue:** Diabetic patients are being told they can't eat or drink in the transportation vendor's car. **Response:** For medical issues it is allowed, but the member is asked to bring the meal in a sealed container. There is also a handout for transportation in the packet for today's meeting.
Quarter 3 - 2018		

MCO	Location/Date of Board Meeting	Issues/Recommendations
BCBS	Albuquerque Main Library Albuquerque, NM July 26, 2018	**Issue**: A member asked how to earn Centennial Reward (CR) points. **Response**: The BCBS Ombudsman had a conference call with the CR representative and resolved the issue for this member. Member is now enrolled and earning Centennial Rewards. **Issue:** Member has a disabled son, but MCO wouldn't give her any information about his plan. **Response:** The BCBS Ombudsman reviewed case and found that there was an alert several months back allowing her to speak on her son's behalf when she calls the MCO. Issue was resolved. **Issue:** There were several transportation issues brought up during the meeting with Logisticare. **Response:** All transportation issues were resolved once the member met with the Logisticare representative at the end of the meeting.
Molina	Zuni Wellness Center Zuni Pueblo, NM July 20, 2018	Members were informed that Molina Healthcare will continue to provide Medicaid coverage until the end of 2018 and that they were not selected to be an MCO under Centennial Care 2.0. **Issue:** A person asked how to get a care coordinator. **Response:** Molina explained the Health Risk Assessment (HRA) process and how a care coordinator gets assigned.
PHP	Jicarilla Health Center Dulce, NM August 3, 2018	Presbyterian (PHP) met with about six members at their Native American Advisory Board meeting. They discussed care coordination, the Presbyterian Financial Assistance program, Centennial Care Rewards, and introduced the PHP Ombudsman. The DME provider, HME, was present for the meeting as well. No concerns.
UHC	UHC did not have a Native American Advisory Board meeting for Quarter 3.	
Quarter 2 - 2018		
BCBS	Gallup Community Services Center Gallup, NM April 18, 2018	**Issue**: The question was asked "If you lose your member ID card, can you get a new one?" **Response**: You can call the toll free number with BCBS and request a new one. (BCBS staff assisted member after the meeting.) **Issue:** What is the timeframe to call ahead for transportation? **Response:** You need to call 72 hours in advance to arrange transportation. **Issue:** Can this (Medicaid) insurance be used out of state?

MCO	Location/Date of Board Meeting	Issues/Recommendations
		Response: Only in emergency situations. For other services, you will need to call Customer Service ahead of time because it might not be covered.
Molina	Zuni Wellness Center Zuni Pueblo, NM July 20, 2018	Members were informed that Molina Healthcare will continue to provide Medicaid coverage until the end of 2018 and that they were not selected to be an MCO under Centennial Care 2.0. **Issue:** A person asked how to get a care coordinator. **Response:** Molina explained the Health Risk Assessment (HRA) process and how a care coordinator gets assigned.
Molina	Zuni Wellness Center Zuni Pueblo, NM June 20, 2018	Molina Healthcare members were informed that if qualified services are rendered at IHS, they will need to call the 800 number to manually redeem their Centennial Reward points since IHS claims billing system is different. **Issue:** A member stated her grandson has an addiction and would like to know how Peer Support Services can help her with her grandson. **Response:** The Peer Support Supervisor provided his business card so that her grandson may contact him, even if he is not a Molina Healthcare member. After receiving several questions about that status of Molina Healthcare in 2019, the Native American Affairs Manager informed members that Molina Healthcare was not selected to be an MCO for Centennial Care 2.0 starting January 1, 2019. Molina Healthcare will continue to provide Medicaid coverage until the end of 2018.
PHP	New Mexico Cancer Center Gallup, NM April 20, 2018	**Issue**: A member indicated he had trouble getting transportation to an appointment and ended up walking. **Response**: PHS made sure the member had the right number to call for future appointments. They also explained how to file a complaint if he chose to. **Issue:** A member asked how to change their status with Medicaid if they need to. **Response**: PHS replied they can call Conduent or go to their Patient Benefits Coordinator (PBC) at IHS.
UHC	Farmington Marriot Courtyard Farmington, NM June 7, 2018	UHC informed group that they were not selected for Centennial Care 2.0 and are appealing the decision. However, they are operating business as usual in the meantime. **Issue**: Member had a comment about transportation vendor not showing up on time and asked for the rules

MCO	Location/Date of Board Meeting	Issues/Recommendations
		regarding an attendant going with the member to appointments. **Response**: Logisticare (transportation provider) went over the guidelines for members to bring an attendant with them to appointments.
Quarter 1 - 2018		
BCBS	Zuni Tribal Conference Center Zuni, NM March 22, 2018	**Issue**: How do we know if an HRA has already been completed? **Response**: We can have a care coordinator check in our system to see if the member's HRA is completed. **Issue**: Sometimes appointments come unexpected. How can I give 72-hour notice in that case? **Response**: It is possible to get an urgent care transportation appointment by calling Logisticare. This will depend on availability. **Issue**: I completed my HRA, but my husband didn't. I asked if I could do the HRA for him and they told me no. Since that time, he has not completed an HRA. **Response:** If you do not have Power of Attorney for your husband, you do not have legal permission to do the HRA for him.
Molina	Native American Community Academy Albuquerque, NM March 7, 2018	**Issue:** Why do I have co-pays if I am Native American? **Response:** Native Americans do not have copays under Centennial Care. If your card is showing copays, you may not be entered in the system as Native American. **Issue:** I have the DD Waiver. How do I qualify for Community Benefits because I need home modifications, medical equipment, and personal care services. **Response:** The minutes did not reflect a response.
PHP	Pueblo of Zuni Tribal Headquarters Zuni, NM March 9, 2018	**Issue:** How can I switch my MCO? **Response**: Member was given Native American FAQs on switching MCOs as well as information on open enrollment beginning October 2018. **Issue**: How can I get a care coordinator? **Response**: The member or family member can request a care coordinator. You can contact the member services call center at Presbyterian. **Issue:** How can I get a ramp for my home? **Response:** Your care coordinator can you help you with home modifications. She will begin the process with an assessment and help you with the process.

MCO	Location/Date of Board Meeting	Issues/Recommendations
UHC	Future Foundation Family Center Grants, NM March 14, 2018	**Issue:** Do members receive mileage reimbursement if they go to the ER? **Response:** Yes, they can receive mileage reimbursement if they call the same day to receive a Trip Number for the ER visit. **Issue:** Do you have to receive verification once someone is discharged from the hospital? **Response**: No, you do not need any verification once being discharged.

Update on Enhanced FMAP for Services Received Through an IHS Facility:

100% FMAP for Services Received through an IHS/Tribal 638 Facility

Albuquerque Area IHS (AAIHS) and UNMH

UNMH continues to bill for the FMAP for FFS members as well as Native Americans in an MCO referred by IHS.H UNMH is in the final stages of having a CCA in place with two Tribal 638 facilities.

Navajo Area IHS (NAIHS) and UNMH

The CCA between UNMH and Navajo Area IHS was signed 09/26/2018.

AAIHS and Presbyterian

Presbyterian began claiming the FMAP for services referred by IHS 05/01/2018. Currently they are only identifying claims for FFS members.

NAIHS and Presbyterian

Navajo Area IHS will be working with PHS on developing a CCA in the future. No specific dates have been set for a meeting.

Formal Tribal Consultations in DY5

HSD did have any formal Tribal Consultations in 2018.

SECTION VII: QUALITY STRATEGY/HCBS ASSURANCES

Quality Strategy

New Mexico's Quality Strategy is a coordinated, comprehensive, and proactive approach to drive quality through targeted initiatives, monitoring, and ongoing assessment of outcome-based performance improvement. The Quality Strategy was reassessed and revised in late 2018 to refine current Quality Management and Quality Improvement (QM/QI) activities and to address new and ongoing initiatives of Centennial Care 2.0. The revisions build upon the program's accomplishments and maximize opportunities for targeted improvements and other modifications to the States Medicaid Program. The revised version is in the process for public comment and tribal notifications have been sent in accordance with regulatory requirements. Once comments are reviewed and considered, the draft Quality Strategy will be submitted to CMS for approval.

The ongoing implementation of quality initiatives and monitoring on the effectiveness of these initiatives is driven by the commitment to provide access, quality and appropriateness of care to Medicaid Beneficiaries.

The MCOs are contractually required to develop policies and procedures that align with The State's established program and healthcare delivery standards. The MCO contract also includes the required monitoring and reporting activities to ensure compliance with the following:

- Network Adequacy and Availability;
- Continuous Quality Improvement;
- Utilization Management;
- MCO Accreditation;
- Performance Measures;
- Tracking Measures;
- Performance Improvement Projects;
- Transitions of Care; and
- Home and Community Based Services Waiver Assurances.

Many of the quality strategy activities have been explained in other sections of this report. Please refer to Section II for information related to Quality Assurance, Access and Network Adequacy, Care Coordination and Adverse Incidents Monitoring. For information on activities related to; Utilization Management; Performance Measure Monitoring; Performance Improvement Projects; and Member Satisfaction, please refer to Section V.

SECTION VIII: STATE CONTACTS

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SECTION IX: ENCLOSURES/ATTACHMENTS

Attachment A: Annual Budget Neutrality Monitoring Spreadsheet
Attachment B: 2018 Value Added Services
Attachment C: 2018 NM Consumer and Family Executive Summary
Attachment D: 2017-18 GeoAccess PH All MCOs
Attachment E: 2017 BH GeoAccess BH All MCOs
Attachment F: Key Utilization/Cost per Unit by Major Population Group