Centennial Care Waiver Demonstration

Section 1115 Quarterly Report
Demonstration Year: 1 (1/1/2014 – 12/31/2014)
Federal Fiscal Quarter: 2/2014

8/29/14

New Mexico Human Services Department

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Section I: Introduction

Program Goals

Prior to Centennial Care, New Mexico's Medicaid program served one-quarter of its citizens through a fragmented delivery system, operating under a myriad of federal waivers, administered by seven different managed care organizations (MCOs) and a fee-for-service (FFS) component. Medicaid accounts for nearly 20% of the State's total General Fund budget each year. In State Fiscal Year (SFY) 2012, New Mexico and the federal government spent approximately four billion dollars on Medicaid services for New Mexicans. With the Governor's decision to expand Medicaid to newly eligibles beginning in January 2014, the State projected an addition of approximately 170,000 new enrollees to the program by June 2015. All of these factors, combined with rising program costs, necessitated modernization of the Medicaid program.

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

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

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

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

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

Key Dates

In August 2012, HSD submitted its Section 1115 demonstration waiver proposal to the Centers for Medicare & Medicaid Services (CMS) and released its competitive procurement to secure the MCOs that would administer the new integrated program. HSD received proposal submissions from bidders in November 2012 and awarded contracts to four MCOs in February 2013. In order to conduct a comprehensive readiness review process, the contracts were awarded almost a full

year in advance of Centennial Care's commencement on January 1, 2014. The Centennial Care MCOs are:

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

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

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

The Centennial Care program was fully implemented on January 1, 2014.

Section II: Enrollment and Benefits

Eligibility

As noted in Section III of this report, 160,021 new adult enrollees in the expansion/VIII group were in Centennial Care as of the end of the reporting period — 34,498 enrollees more than the prior quarter. The parent/caretaker Medicaid category increased from 27,975 to 33,342 recipients, which is an increase of 5,367 recipients from the prior quarter, primarily due to the expansion of Medicaid.

Enrollment

Centennial Care enrollment has continued to increase each month of the second quarter. Expansion of Medicaid eligibility has contributed to the overall increase in enrollment. The majority of Centennial Care members are enrolled in Population 1 – Temporary Assistance for Needy Families (TANF) and Related with Population 6 – Group VIII (expansion) being the next largest group as reflected in Section III of this report. Centennial Care enrollment increased by 39,185 members in the second quarter.

Disenrollment

HSD has identified and addressed isolated disenrollment of Centennial Care members in the second quarter. This isolated disenrollment was linked to the processing of the eligibility file between the Automated System Program and Eligibility Network (ASPEN) that determines eligibility and the Medicaid Management Information System that determines enrollment in and disenrollment from Centennial Care. A short-term solution has been applied to address the disenrollment issue until a long-term correction can be implemented.

Access

Access to agencies, providers, and a full array of services is critical to the success of the demonstration, especially when considering member growth and expansion. New Mexico is the fifth largest state by area, has a low population density and has just four cities with populations of 50,000[1] or more. Four counties are designated as urban, 14 as rural, and 15 as frontier areas. According to the Health Resources and Services Administration (HRSA), all of the State's counties have health professional shortage areas in whole or in part[2]. Centennial Care MCOs must remain attentive to geographic access in order to meet contract standards, HSD determined distance requirements, and provider-to-member ratios.

Primary Care Provider (PCP)-to-Member Ratios

As shown in the table below, all four MCOs were in compliance for PCP-to-member ratios rather than three, which had been reported last quarter. Each MCO was well within the established ratio of 1:2000 from January through May 2014. June reports are currently being reviewed (see Section XIV: Managed Care Reporting Requirements – MCO Reporting Process).

[1] US Census Bureau, (2012) Retrieved from: https://www.census.gov/popest/data/cities/totals/2012/

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

Table 1. PCP-to-Member Ratios by MCO

	Jan	Feb	Mar	Apr	May
BCBS	1:36	1:42	1:44	1:47	1:49
UHC	1:6	1:8	1:9	1:10	1:12
Molina	1:85	1:90	1:91	1:93	1:93
PHP	1:81	1:85	1:81	1:81	1:82

Source: [MCO] PCP Report # 53, January—May, 2014

The PCP-to-member ratio is calculated as of the last day of the reporting period, and calculated by dividing the total number of non-dual members by the total number of PCPs.

Open Panels

There continues to be a high percentage of PCP open panel slots for all MCOs. The percentages range from a low of 82% to a high of 98%.

Geographic Access

Each Centennial Care MCO covers all geographic regions of New Mexico. Geographic access to providers is being monitored closely, especially for those services that are new to some of the Centennial Care MCOs such as LTC, including nursing facilities (NFs), personal care services, and BH services. Indian Health Service (IHS), Tribal health providers, and Urban Indian providers (I/T/Us) are not required to contract with the MCOs under Centennial Care. Native American Centennial Care members may access services at I/T/Us at any time and the Centennial Care MCOs must pay I/T/U claims at the Office of Management and Budget (OMB) rate.

Distance Requirements

Pursuant to each MCO contract, the following distance requirements must be met for PCPs and pharmacies.

Standard 1

- Ninety percent of urban members shall travel no farther than 30 miles.
- Ninety percent of rural members shall travel no farther than 45 miles.
- Ninety percent of frontier members shall travel no farther than 60 miles.

Additionally, HSD sets distance requirements for all other provider types, as noted below in Standard 2.

Standard 2

- Ninety percent of urban members shall travel no farther than 30 miles.
- Ninety percent of rural members shall travel no farther than 60 miles.
- Ninety percent of frontier members shall travel no farther than 90 miles.

Physical Health

The Geographic Access Table below shows that all MCOs met access and distance requirements for PCPs, pharmacies, and federally qualified health centers (FQHCs) in the first quarter. All

MCOs met access and distance requirements for Cardiology, Dental, Obstetrics and Gynecology (OB/GYN), and Podiatry. All MCOs met distance requirements for certified nurse practioners, physician assistants, and surgeons.

The table also shows that most MCOs met access and distance requirements for the following physician specialists: ear, nose and throat (ENT), hematology/oncology, orthopedics, pediatrics, urology, and certified midwives. There are several specialty areas for which there is a shortage of providers, particularly in the rural and frontier areas. These service specialties include: dermatology, endocrinology, neurology, neurosurgery, and rheumatology. Some activities identified by MCOs to address these shortages include the following: locating potential providers in specialties of concern and approaching each to be contracted with the MCO; identifying providers interested in the use of telemedicine, when applicable; providing assistance to members with referrals to the closest available providers; utilizing single-case agreements to out-of-network providers; and providing members with transportation to specialists.

There are currently nine rural health centers (RHCs) in New Mexico. BCBS reported that it contracts with seven. UHC grouped RHCs with FQHCs; HSD is addressing this innacuracy in the reporting. Molina contracted with eight RHCs, and PHP reported that it contracts with all nine RHCs. Meeting the RHC distance standard is affected by the overall number of enrolled members and the population density of members in certain areas of the State.

While I/T/Us are not required to contract with MCOs, the MCOs may have agreements with these providers; therefore, distance requirements for I/T/Us are measured and included in the Geographic Access Report. I/T/Us are predominantly located in the Central (Rio Grande) and Northwest (Four Corners) areas of the State. While populations other than Native Americans may receive services at these agencies/facilities, I/T/Us are concentrated near or on tribal land where the majority of Native Americans live and receive services. This affects the performance results as Medicaid members located in other rural and frontier areas are not excluded from the population used to calcuate the measure.

Long-Term Care

Access and distance requirements for LTC services were almost entirely met. The one service that did not meet the distance requirement is assisted living, mainly in rural areas. However, a limited number of agencies offer these services, and there are no applications pending from agencies seeking to become a Medicaid provider. Contract managers monitor provider contracting status for all services, and for each MCO, on a weekly basis (see Section VI: Operations – Weekly Status Update Ad Hoc Reporting).

Behavioral Health

General hospitals with psychiatric units are available in urban areas; only one MCO did not meet distance requirements, but was close at 86.9%. All MCOs met distance requirements for Inpatient Psychiatric hospitalization in urban areas. Access in rural and frontier areas did not meet distance requirements. Freestanding Psychiatric hospitals, partial hospital programs and residential treatment centers (RTCs) in all areas, including urban areas, did not meet distance requirements and probably will not, due to the limited number of such facilities in the State.

HSD acknowledges that the number of Inpatient treatment facilities and (accredited and non-accredited) RTCs may not meet distance standards, because Outpatient, community-based service agencies are often the least-restrictive and clinically preferred course of treatment. However, while there are a limited number of licensed and certified RTC facilities in New Mexico, there is adequate bed capacity for high acuity members who need this type of care. In addition, there is not necessarily a "shortage" of these facilities but a policy implementation effort to drive the BH system toward a community-based system rather than an institutionally based one. Community-based services provide proximity to a member's home/community, family, and established support networks, which promote member connection and engagement. Nevertheless, MCOs have been directed to continue to contract with Inpatient facilities and RTCs in order to meet HSD distance requirements and to use single-case agreements, when necessary, especially when there are facilities close to a member's community.

BCBS reported one RHC providing BH services in its network. UHC grouped RHCs providing BH services with FQHCs and reported them together. Molina reported four. PHP reported that none of the RHCs that it contracts with are providing BH services. There appears to be some confusion as to which RHCs provide BH services. Whether RHCs are not providing BH services, or whether they are not contracted for those specific services, will be clarified with the MCO(s).

Areas of strength, where all MCOs meet distance requirements in urban, rural, and frontier areas, include: core service agencies (CSAs), psychiatrists, and other licensed, independent BH providers. With some exceptions, distance requirements have been met for FQHCs providing BH services, community mental health centers, agencies providing Behavioral Management services and psychologists, including those with prescribing authority, Outpatient provider services, Intensive Outpatient services, and treatment foster care. Access requirements have predominantly not been met for agencies providing specific treatments such as: day treatment, assertive community treatment (ACT), and multi-systemic treatment (MST). Initiatives to assess and address the deficit of access to these services are in early stages. BCBS stands out for meeting distance requirements for Suboxone certified MDs in all regions. Because BCBS has a high member enrollment and was still able to meet distance requirements, it would appear that a sufficient number of providers are available for the other MCOs to contract with. UHC is focusing on network development for methadone clinics because it does not meet the distance requirements in urban, rural, or frontier areas. HSD will continue to monitor MCO progress in contracting for these services and providers, as well as network development for other services needed for complex members, including ACT and MST.

Transportation

Distance requirements have been meet by all MCOs in urban areas. BCBS did not meet standards in rural counties Chaves, Curry, Rio Arriba, and Roosevelt and frontier counties Catron, DeBaca, and Quay. UHC did not meet standards in rural county Chaves and frontier counties Catron, Cibola, Colfax, DeBaca, Guadalupe, Harding, Quay, and Sierra. HSD has requested a corrective action plan (CAP) from the two MCOs and their commonly contracted transportation vendor, Logisticare. This will be reported in the third quarter report.

Table 2. Geographic Access (January 1 - March 31, 2014)

Green = Meets, Orange = Does not meet - contract standards; nd = no data provided by MCO

	Urban				Rural				Frontier			
PH - Standard 1	**BCBS**	**UHC**	**MH**	**PHP**	**BCBS**	**UHC**	**MH**	**PHP**	**BCBS**	**UHC**	**MH**	**PHP**
PCP including Internal Medicine, General Practice, Family Practice	99.1%	100%	100%	100%	99.8%	100%	100%	100%	97.0%	97.5%	100%	99.9%
Pharmacies	100%	100%	100%	100%	100%	100%	100%	100%	99.1%	99.8%	99.0%	99.6%
FQHC	99.1%	100%	100%	100%	100%	99.0%	100%	99.9%	100%	97.8%	98.0%	99.3%
PH - Standard 2												
Cardiology	99.1%	98.8%	98.0%	99.0%	98.5%	99.4%	100%	91.7%	99.6%	99.8%	100%	97.7%
Certified Nurse Practitioner	99.1%	100%	99.0%	100%	99.7%	100%	100%	100%	99.9%	100%	100%	100%
Certified Midwives	94.7%	96.2%	98.4%	95.6%	78.4%	97.6%	88.0%	94.0%	90.7%	97.6%	98.0%	98.9%
Dermatology	70.7%	72.6%	77.0%	85.2%	38.2%	48.6%	60.0%	66.6%	61.4%	75.4%	91.0%	77.8%
Dental	100%	100%	100%	100%	100%	99.7%	100%	100%	100%	99.9%	100%	100%
Endocrinology	93.4%	94.9%	78.0%	98.8%	43.5%	86.2%	42.0%	64.4%	75.8%	85.0%	84.0%	78.8%
ENT	99.0%	98.7%	99.0%	60.0%	98.2%	92.6%	98.0%	99.0%	94.1%	93.1%	94.0%	98.4%
FQHC	99.1%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
RHC	99.2%	with FQHCs	1.0%	0.0%	38.4%	with FQHCs	52.0%	27.6%	55.2%	with FQHCs	76.0%	41.2%
Hematology/ Oncology	99.0%	98.7%	98.0%	99.0%	70.2%	99.0%	62.0%	96.5%	99.3%	99.8%	100%	99.4%
I/T/U	70.7%	0.0%	89.0%	79.0%	44.4%	3.4%	89.0%	68.4%	82.3%	36.1%	95.0%	86.5%
Neurology	98.4%	94.9%	98.0%	98.8%	82.2%	89.1%	92.0%	86.9%	89.8%	88.8%	89.0%	90.3%
Neurosurgeons	99.0%	98.5%	78.0%	99.0%	31.1%	41.3%	32.0%	67.2%	70.6%	71.5%	59.0%	86.5%
OB/Gyn	99.1%	98.8%	99.0%	99.1%	99.7%	99.4%	100%	99.6%	99.8%	99.7%	99.0%	100%
Orthopedics	99.1%	96.1%	98.0%	99.0%	89.5%	93.3%	100%	94.7%	90.9%	97.3%	98.0%	96.1%
Pediatrics	99.1%	98.8%	98.0%	99.1%	99.7%	99.4%	81.0%	99.5%	99.9%	97.7%	97.0%	99.0%
Physician Assistant	99.1%	96.2%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Podiatry	99.0%	95.5%	98.0%	99.1%	94.2%	99.4%	100%	98.6%	99.9%	99.9%	98.0%	99.9%
Rheumatology	88.5%	94.9%	98.0%	99.0%	49.6%	69.2%	79.0%	83.7%	80.3%	84.9%	94.0%	86.4%
Surgeons	99.1%	98.8%	98.0%	99.1%	99.7%	99.4%	100%	94.9%	99.9%	99.8%	100%	100%
Urology	94.6%	98.7%	65.0%	99.0%	91.1%	99.0%	95.0%	94.6%	92.5%	94.3%	97.0%	95.5%
LTC - Standard 2												
Assisted Living Facilities	95.4%	94.6%	100%	83.5%	60.8%	60.2%	64.0%	67.1%	88.4%	93.5%	100%	99.9%
Personal Care Service (PCS) Agencies — delegated	98.4%	98.8%	100%	100%	99.1%	99.4%	100%	99.1%	99.3%	100%	100%	100%
PCS Agencies — directed	86.8%	98.8%	100%	99.2%	99.1%	99.4%	100%	99.1%	99.2%	100%	100%	100%
Nursing Facilities	94.7%	95.1%	96.0%	96.5%	98.6%	97.8%	93.0%	97.5%	99.9%	99.0%	100%	99.9%

Source: [MCO] Geographic Access Report #55, Q1FY14

Table 2. Geographic Access (January 1 - March 31, 2014) continued

Green = Meets, Red = Does not meet - contract standards; nd = no data provided by MCO

	Urban				Rural				Frontier			
BH - Standard 2	**BCBS**	**UHC**	**MH**	**PHP**	**BCBS**	**UHC**	**MH**	**PHP**	**BCBS**	**UHC**	**MH**	**PHP**
Freestanding Psychiatric Hospitals	98.4%	98.4%	34.0%	20.0%	67.2%	73.6%	11.0%	3.8%	76.5%	98.3%	56.0%	43.4%
General Hospitals with psychiatric units	86.9%	98.4%	94.0%	95.3%	27.7%	73.9%	76.0%	82.4%	44.7%	95.8%	87.0%	81.1%
Partial Hospital Programs	81.1%	nd	27.0%	7.3%	19.8%	nd	5.0%	0.0%	44.7%	nd	19.0%	0.7%
Accredited Residential Treatment Centers (ARTC)	87.0%	98.7%	84.0%	99.0%	31.3%	85.8%	21.0%	55.2%	67.2%	97.6%	69.0%	73.2%
Non-Accredited Residential Treatment Center & Group Homes	98.6%	98.6%	65.0%	82.9%	62.7%	93.7%	66.0%	60.4%	70.6%	93.3%	81.0%	75.2%
Treatment Foster Care I & II	94.2%	98.8%	93.0%	95.4%	66.6%	92.3%	60.0%	83.8%	85.8%	99.8%	91.0%	90.3%
Core Service Agencies	99.0%	98.8%	94.0%	99.0%	95.0%	99.5%	95.0%	99.5%	100%	100%	100%	100%
Community Mental Health Centers	98.7%	98.8%	65.0%	98.1%	65.6%	99.5%	87.0%	99.6%	100%	100%	93.0%	99.8%
Indian Health Service and Tribal 638s providing BH	69.9%	72.5%	89.0%	nd	44.4%	59.5%	89.0%	nd	81.7%	84.3%	95.0%	nd
Outpatient Provider Agencies	80.1%	99.0%	94.0%	95.5%	28.6%	100%	48.0%	86.6%	52.7%	100%	82.0%	99.9%
Agencies providing Behavioral Mgmt. Srvs.	99.0%	98.8%	98.0%	99.0%	68.0%	93.4%	52.0%	81.9%	100%	100%	100%	99.8%
Agencies providing Day Treatment Services	80.1%	98.8%	88.0%	65.4%	40.7%	71.3%	38.0%	37.5%	47.6%	89.2%	72.0%	43.1%
Agencies providing Assertive Community Treatment	58.5%	98.8%	98.0%	65.5%	19.0%	85.9%	52.0%	62.5%	44.6%	100%	86.0%	72.4%
Agencies providing Multi-Systemic Therapy	78.1%	94.8%	56.0%	95.4%	49.0%	87.3%	15.0%	75.5%	84.7%	92.0%	50.0%	81.2%
Intensive Outpatient Services	81.4%	98.7%	98.0%	79.0%	79.3%	92.5%	100%	80.0%	65.9%	99.7%	100%	98.8%
Methadone Clinics	58.5%	72.5%	56.0%	79.0%	18.8%	33.5%	15.0%	47.0%	34.8%	79.3%	50.0%	65.3%
FQHCs providing BH services	99.0%	100%	98.0%	99.1%	84.6%	88.7%	63.0%	85.9%	86.6%	100%	96.0%	99.1%
Rural Health Clinics providing BH Services	0.0%	with FQHCs	0.0%	0.0%	0.2%	with FQHCs	37.0%	0.0%	18.9%	with FQHCs	32.0%	0.0%
Psychiatrists	99.0%	98.9%	100%	100%	91.6%	98.9%	100%	96.4%	94.8%	99.1%	100%	99.8%
Psychologists	94.0%	98.9%	99.0%	95.8%	52.7%	86.7%	100%	85.2%	75.2%	99.7%	100%	92.4%
Suboxone certified MDs	99.1%	58.3%	98.0%	79.0%	85.0%	30.7%	94.0%	54.8%	100%	46.4%	97.0%	65.5%
Other Licensed Independent BH practitioners	99.1%	99.0%	100%	100%	99.9%	100%	100%	99.8%	100%	99.8%	100%	100%
Hospitals - Standard 2												
General Hospitals	99.1%	94.8%	99.0%	99.1%	99.4%	94.8%	100%	99.6%	100%	99.1%	100%	99.8%
Inpatient Psych Hosp.	98.4%	98.7%	99.0%	98.8%	67.2%	98.7%	76.0%	84.5%	76.5%	98.3%	87.0%	81.7%

Table 2. Geographic Access (January 1 - March 31, 2014) continued

Green = Meets, Red = Does not meet - contract standards; nd = no data provided by MCO

Transportation	Urban				Rural				Frontier			
	BCBS	UHC	MH	PHP	BCBS	UHC	MH	PHP	BCBS	UHC	MH	PHP
Urban Counties: 90% within 30 miles	99.0%	98.7%	100%	100%								
Rural Counties: 90% within 45 miles					79.4%	83.8%	100%	100%				
Frontier Counties: 90% within 60 miles									93.1%	71.7%	100%	100%

Source: [MCO] Geographic Access Report #55, Q1FY14

For BH services requiring facility based or higher levels of care, HSD is monitoring a policy implementation effort to drive the BH system toward a community-based system rather than an institutionally based one.

Service Delivery

As shown in the table below, the majority of prior authorization (PA) requests were approved in the first quarter. Analyses provided by the MCOs indicate that pending requests were primarily due to a large influx of requests in January. BCBS reported that the pending requests were evaluated and decreased throughout the quarter. BCBS also reported that turnaround times (TATs) improved over time. Anomalies that stand out from the data are as follows: the high percentage of Dental denials across MCOs; the percent of BH denials by BCBS, the number of LTC pending requests by BCBS, the requirement for UHC to resubmit their report, and the low overall number of PH and BH PA requests for PHP.

A high percentage of Dental service denials were reported by each MCO. This suggests that training is needed for Dental provider staff with respect to determining member eligibility, the services which are covered, and the information required for PA approvals. This information has been disseminated by the MCOs; MCOs will provide additional trainings as needed.

BCBS reported in its analysis that it has reduced the number of pending authorizations by enlisting the help of care coordinators in obtaining required clinical documentation. BCBS also reported having improved TAT for PA requests each month since January. BCBS did not address the percentage of denials (21.8%) for BH services. The services which received the most denials were Acute Inpatient Psychiatric hospitalization with 132 reductions in service and accredited RTC with 12 reductions in service. Overall, there were 149 reductions in service denials, three clinical denials, one administrative denial, and one termination of services. There were a total of 701 authorization requests. Denials for BH services will be monitored closely by HSD Behavioral Health Services Division (BHSD), and further review may be requested.

UHC stated in its analysis that a lag in reporting by its business partners resulted in an incomplete report and they must resubmit to HSD. Though the delay is caused by a third party vendor, it is still considered a failure to report. UHC has been advised that any report submissions made without all of the required data elements will be rejected and subject to potential sanctions.

The overall number of BCBS requests for both PH and BH was approximately half that of Molina. These numbers align in that BCBS has approximately half of the enrolled members as Molina. PHP had approximately the same number of enrolled members as Molina, but it had approximately one-quarter of the overall PH PA requests and one-third of the BH PA requests as did Molina. While PHP had a high approval rate of 95.9% and 91.3%, respectively, it does not explain the relatively low number of overall requests. HSD is aware that PHP has a large population of healthy members; however, it will request further analysis.

Table 3. Prior Authorizations, Q1FY14

	BH Total PAs Requested	Approved	Denial or Reduction in Services	Pending	PH Total PAs Requested	Approved	Denial or Reduction in Services	Pending
BCBS	701	76.9%	21.8%	8	8,156	96.5%	1.0%	159
UHC	Report Resubmission Required				Report Resubmission Required			
Molina	1,321	100.0%	0.0%	0	16,261	99.1%	0.7%	37
PHP	438	91.3%	7.8%	4	4,588	95.9%	3.1%	47
	LTC Total PAs Requested	**Approved**	**Denial or Reduction in Services**	**Pending**	**Dental Total PAs Requested**	**Approved**	**Denial or Reduction in Services**	**Pending**
BCBS	7,712	91.0%	0.0%	616	4,426	47.7%	52.3%	0
UHC	Report Resubmission Required				Report Resubmission Required			
Molina	5,991	99.8%	0.2%	0	5,368	48.7%	51.3%	0
PHP	1,216	93.2%	1.2%	65	8,058	51.7%	48.3%	0

The current Utilization Management (UM) Report is limited to BH services and is currently under revision. Changes anticipated include adding PH, LTC, Pharmacy, and Transportation services. In the meantime, an ad-hoc report was initiated to provide an overview of utilization based on claims data and unique members per MCO by service from January 1 through July 1, 2014. An analysis was made comparing the amount expended per unique member between MCOs.

When the average cost per unique member spent by the MCOs was compared, the variance in expenditures was most pronounced in BH and LTC services, as well as PH hospital stays, Solvaldi and Suboxone. While there isn't enough information to draw conclusions at this time, these utilization and expenditure patterns will be evaluated further during the demonstration.

Also interesting is the number of unique members utilizing services. HSD will request additional analyses from the MCOs in terms of providing the right care, at the right place, and at the right time. For example, 117,453 unique members utilized non-Emergency Transportation. While the use of non-Emergency Transportation improves access, it may also be helpful to determine if there are identifiable healthcare needs concentrated in specific areas of the State. Another example is that 84,754 unique members are utilizing psychotropic medications while 12,826 members utilize Psychiatric services. Certainly there are other qualified practitioners including physicians, psychologists and nurse practitioners with prescribing authority; however, it may

also be beneficial to evaluate this in terms of efficacy. HSD anticipates the implementation of the revised UM Report in the third quarter.

Pharmacy

Early in implementation, there were instances of MCO delays in loading member enrollment files. When this occurred, HSD staff directed the appropriate MCO to manually enter the data so that the member could obtain access to services, including Pharmacy, immediately. These types of issues subsided in the second quarter.

HSD staff reviews monthly MCO Pharmacy reports. Any requests to confirm data are initiated by the contract managers either by email or by rejecting the report and requiring resubmission. UHC has had five months of rejected reports. The other MCOs have had to confirm specific data and/or resubmit their report(s). The following are several examples of HSD requests for MCO confirmation of data: PHP reported zero eligibility denials, though members had notified HSD of eligibility denials; UHC reported zero denials for "physician not in plan" when the other MCOs reported between 71 and 200.

The MCO monthly Pharmacy report also captures key metrics regarding prescription claims for brand and generic drugs. It is noted that there is a high usage of generic drugs, an 88% average for all four MCOs and therefore, there are no concerns at this time.

Nursing Facilities

For PHP, BCBS, and Molina, Medicaid LTC is a new program. Because of this, there were additional issues that arose and needed to be addressed. Also, additional monitoring activities needed to be put in place. HSD staff, assigned to resolve NF issues, continues to have close contact with MCO staff and providers. This includes daily or weekly meetings, as needed, along with weekly technical assistance calls. There is also continuous contact with the Executive Director of the New Mexico Health Care Association (a NF provider organization) to address any issues and clarify roles in the process. Many provider concerns have been related to claims and reimbursement. One example is that medical care credits indicated in letters sent from the HSD's Income Support Division (ISD) offices do not match those in the Medicaid portal. System changes are being implemented to address this issue. HSD staff is receiving specific requests to correct medical care credits. As these arrive, each request is sent to the appropriate ISD office to review and correct the amounts as applicable.

When a nursing facility level of care (NFLOC) approval is completed, the MCO sends the approval through the interface to the ISD office where Medicaid eligibility is completed. Settings of care (SOC) are not always accurate. HSD receives specific member information, and the MCO is contacted to correct the SOC to institutional care by using the MCO/HSD interface. MCOs have been very responsive to these requests.

During the reporting period, there was some confusion on the part of the MCOs regarding Medicaid coinsurance payments for those individuals on Medicare. HSD presented trainings to the MCOs in September and November 2013. Approximately 60 people attended the September training and 30-40 attended the November training. Beginning August 1, 2014, there will be a separate training for each MCO to directly address specific issues.

The Executive Director of the New Mexico Healthcare Association was asked to continue regular meetings with the MCOs to address ongoing concerns. HSD stays in close communication with the Executive Director to assist with resolution of issues.

The MCOs will be asked to provide data regarding their timely approval of NFLOC requests. They are required to review these requests within five business days of receipt of completed packets. Providers have voiced concerns that the turnaround times have been longer. When HSD receives the MCOs' information regarding the turnaround time for NFLOC review, it will analyze and determine follow-up actions.

HSD maintains an ongoing, updated grid with provider-/MCO-specific concerns related to NFs. Progress is monitored on a daily basis. Using specific examples has helped the HSD/Medical Assistance Division (MAD) Systems Bureau to research issues and correct problems.

Through close collaboration with the New Mexico Department of Health (DOH), HSD is informed regarding the status of NFs' compliance and noncompliance with statutory requirements. Joint investigation might reveal that the facility is not submitting claims correctly and thus the claims are denied. In those cases, the MCO(s) with residents in the facility will be contacted by HSD to reach out to the facility and provide training in submission of clean claims. This collaboration will continue to be fostered.

Provider Network

The provider network has been covered in detail under the Access Section of this report. In addition to network adequacy and access to providers and services, HSD evaluates trends regarding new and terminated providers. HSD also monitors the transition of members to new providers when a provider or agency is suspended or terminated. Member-to-provider ratios and the number of single case agreements required during the quarter are considered with respect to provider adequacy and the strength of each MCO's network. Any concerns with the MCO are addressed by the contract manager. In the second quarter, the MCOs have continued outreach and contracting with providers and agencies who offer specialty services in PH or BH.

Centennial Rewards Program

The second quarter saw the full implementation of the Centennial Rewards program. While members could start earning credits for "healthy choices" activities on January 1, 2014, the Centennial Rewards website, catalog, and call center did not become operational until April 1, 2014. And while members could earn points for all activities since January 1, 2014, not all activities were fully implemented until the end of May 2014 (e.g., data and reporting functions and the rewarding of credits for some activities were not initially operational). All activities are now fully functional and operational, including:

- Healthy Smiles — annual Dental check-up (child and adult).
- Healthy Babies — joining the MCO prenatal program.
- Bone density testing — for women age 65+.
- Asthma management — inhaler refills.
- Diabetes management — completion of appropriate diagnostic tests.
- Medication management (schizophrenia).

- Medication management (bi-polar disorder).

As of June 30, 2014, 133,870 members had earned credits for one or more of the program's healthy activities. The great majority of these members earned their points for the Dental visit. Of those earning credits, 6,526 registered for the program either on the Centennial Rewards website or through the call center. Registration is required in order to redeem credits for rewards and is also a measure of member engagement. The total dollar value of credits earned was $4,610,510. The total dollar value of credits redeemed was $36,753.

This redemption rate of roughly 1% is low, but program outreach and marketing activities were just beginning in the second quarter. The MCOs are starting to distribute additional materials to ensure that members are aware of the program and their related benefits. The Centennial Rewards call center is now making outbound calls to members who have earned credits but not yet registered for the program.

Other notable activities taking place in the second quarter include the implementation of the administrative and public portals. The administrative portal allows HSD to get real-time information regarding various program metrics (credits earned and redeemed, registered users) by MCO and in total. The public portal allows individuals not registered for the program to learn more about Centennial Rewards and see links to valuable health information. The public portal is at www.centennialrewards.com.

For the third quarter, members will be able to redeem credits for the Centennial Rewards debit card. They will be able to use the card just like cash at several retail outlets around New Mexico and will be able to purchase a wide (but restricted) variety of items. Phase II of the administrative portal has also recently gone live, providing HSD with more in-depth information regarding MCO and program performance.

Community Interveners

At this time, the MCOs are contracting with Community Outreach Program for the Deaf (COPD) for Community Intervener (CI) services. HSD has asked the MCOs to contract with other providers for CI services, as they become available. HSD developed a letter of direction (LOD) for the MCOs that outlines who is eligible for CI services, specifies provider qualifications, provides the federal definition for members who are deaf-blind, and includes the hourly reimbursement rate. COPD provides CI services to individuals who are 16 years and older. COPD employs 15 CIs throughout the State. Those receiving this service typically receive approximately twenty 20 to 25 hours per month, but no more than 20 hours per week.

In the reporting period, COPD signed contracts with each MCO and trainings for billing were scheduled. COPD met with its clients from June 30 through July 3, 2014 to identify Medicaid members and MCO affiliations for each. Additionally, COPD plans to have its program coordinator meet with clients to assist them with Medicaid enrollment, if applicable. HSD will provide census and utilization data beginning in the third quarter. The MCOs and COPD will continue trainings for billing and care coordination through the end of July 2014.

Section III: Enrollment Counts

The following table outlines all enrollment activity under the demonstration. The enrollment counts are unique enrollee counts, not member months. Please note that these numbers reflect current enrollment in each Medicaid eligibility group (MEG). If members switched MEGs during the quarter, they were counted in the MEG that they were enrolled in at the end of the reporting quarter.

Table 4: Enrollment Activity

Demonstration Population	Total Number of Demonstration Participants: Quarter Ending June 2014	Current Enrollees (Year to Date)*	Disenrolled in Current Quarter**
Population 1 – TANF and Related	379,737	395,434	18,591
Population 2 – Supplemental Security Income (SSI) and Related – Medicaid Only	41,527	42,336	1,238
Population 3 – SSI and Related – Dual	35,519	36,335	1,088
Population 4 – 217-like Group – Medicaid Only	226	290	20
Population 5 – 217-like Group – Dual	2,274	2,332	58
Population 6 – VIII Group (expansion)	160,021	164,913	10,142
Totals	619,304	641,640	31,137

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

** Defined as clients enrolled during the Reporting Quarter who did not have an enrollment as of the beginning of the subsequent quarter.

Section IV: Outreach

In January 2014, HSD expanded its existing presumptive eligibility/Medicaid on-site application assistance (PE/MOSAA) program for children and pregnant women in accordance with the Affordable Care Act (ACA) to include hospital PE/MOSAA for all new (ACA) categories of eligibility. Further, HSD also expanded the adult PE/MOSAA program to include determinations performed by IHS facilities and prisons, jails and detention centers. Since then, HSD has been actively training current Presumptive Eligibility Determiners (PEDs) around the State to provide more efficient and accessible enrollment opportunities for Centennial Care and other Medicaid programs. The PED training includes information on Centennial Care and the benefits it offers members.

HSD has implemented a new presumptive eligibility system called Yes New Mexico for PEDs (YESNM-PE). PEDs are able to screen individuals for PE and submit applications for ongoing Medicaid eligibility through an efficient web-based system. PEDs may be certified to perform PE/MOSAA for children and pregnant women only, or they may be approved to assist with PE/MOSAA for ACA categories as well. To date, the State has trained 1,188 PEDs and of those, 829 are eligible to screen for all allowed categories of eligibility. These PEDs provide greater access to Medicaid enrollment for more New Mexicans.

Section V: Collection and Verification of Encounter Data and Enrollment Data
All four Centennial Care MCOs are in production for all invoice types — professional, institutional, and dental. Although crossover claims have been a challenge, HSD has worked to provide training and guidance to work through these difficulties. The MCOs are now trying to bring their encounters current by submitting daily and/or weekly production files.

Other than some very specific claim types, all encounters are current for the second quarter. One of the MCOs has completed testing in all categories and is in production with all categories except Crossover claims. Two MCOs have approximately one dozen categories that have been tested but are not yet approved for production. One MCO has approximately two dozen categories that have been tested but are not yet approved for production. The categories that are not yet approved are BH, non-Emergency Transportation, Community Benefit, and Crossovers. The review of the production encounters indicates that the submissions of approved categories satisfy the encounter data requirements.

HSD has identified an issue in encounter submissions due to provider enrollment delays. Unless the provider is enrolled with HSD, the encounter will be denied. There has been a delay because providers are directed to the Medicaid web portal to enroll but the time to process the application can be lengthy. This issue was remediated and the processing time has improved. The provider enrollment application process has been streamlined to shorten the processing time which will allow the MCOs to submit any encounters that were pending. Reporting tools to track the timeliness and accuracy of Centennial Care encounters were developed to ensure that encounters are monitored on a regular basis in accordance with the contract.

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

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

Program Development

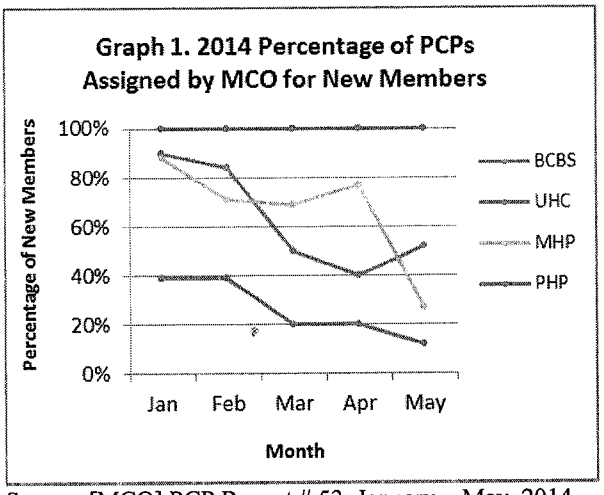
MCO Assigned PCPs and Member Change Requests

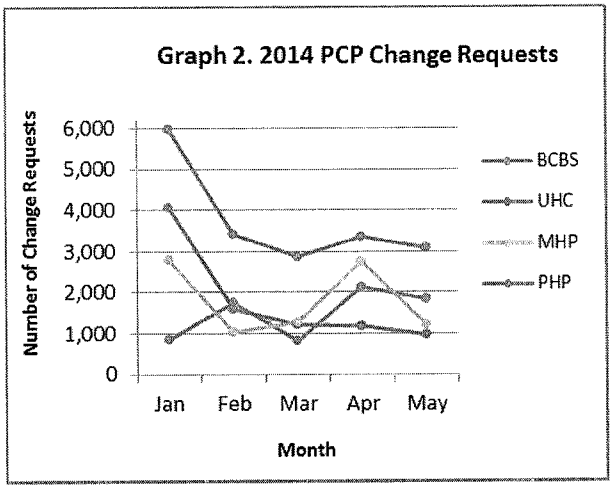
Graph 1 shows the percentage of new members for whom an MCO assigned a PCP. UHC has been reporting that 100% of its new members are assigned to a PCP. The MCO states in its report analysis that its process is to make three attempts to reach each new member by phone within five days from the date the MCO receives the HSD enrollment file. In the event that the member cannot be reached, the member is auto-assigned to a PCP. From January to May, UHC reported a 75.95% decrease in the number of PCP change requests by members. The MCO attributes this decline to the effectiveness of its process.

HSD requested clarification of the sequence of steps in this process. One hundred percent of members assigned to a PCP suggests that members are assigned to a PCP prior to the outreach described. HSD questioned this process and also instructed UHC to exclude Native American members from the PCP auto-assignment process. UHC implemented an action plan to correct both issues (see Section IX, Q1 FY14, #9).

BCBS also implemented an action plan to allow members 15 days to select a PCP prior to being assigned one (see Section IX, Q1 FY14, #5). BCBS was auto-assigning members to PCPs contrary to the 15-day member selection period specified in the Contract [4.8.6].

Graph 2 below shows that PHP reported significantly more PCP change requests, as compared to the other MCOs (even when considering enrollment differences). PHP's average percentage of completed requests per month is significantly lower than the other MCOs (49% as compared to 100%). HSD has requested additional information from PHP regarding its PCP change request process and methodology for reporting.





Source: [MCO] PCP Report # 53, January—May, 2014

Care Coordination

As of July 23, 2014, the MCOs report not having been able to reach approximately 40% of the overall membership. HSD is concerned that members who have not been contacted and assessed may not be receiving the benefit of coordinated care. The status of care coordination efforts and

unreachable members is detailed in the table below. The MCOs report that they are facing unanticipated challenges in locating and engaging members in order to complete the health risk assessments (HRAs) and comprehensive needs assessments (CNAs). HSD is tracking the unreachable member count as reported by the MCOs closely, as well as the MCOs' efforts to locate their members.

HSD directed the MCOs to initiate internal campaigns and identify the efforts they will make in order to connect with their unreachable member populations. MCO plans were submitted to HSD for review and approval on July 1, 2014. Each plan was required to provide details as to how the MCO will achieve a minimum monthly decrease of 10% through September 1, 2014 and a 5% reduction in unreachable members each month thereafter. These efforts, and their results, will be reported in the third quarter.

Table 5. HRAs and CNAs Completed

Care Coordination	BCBS	UHC	Molina	PHP
HRAs				
# HRAs completed for new members	24,598	9,475	14,675	4,347
# HRAs completed for transitioning members	28,114	16,251	63,250	37,679
# Unreachable members	16,835	23,159	44,865	132,024
CNAs				
# CNAs required	9,893	15,850	6,008	3,570
# CNAs completed	5,354	13,227	10,437	3,795

Source: MCO Transition Reports/CCS Comparison Grid (data as of July 23, 2014)

HSD monitors MCO care coordination activities to ensure that sufficient care coordination is being delivered. HSD staff addresses care coordination issues through weekly technical assistance calls with the MCOs. HSD takes necessary steps to ensure effective corrective actions are taken by MCOs, when needed, to ensure compliance with contract standards (see Section IX: Action Plans Q1 and Q2 FY14).

For example, when a member has filled the same drug class more than three times in one month, the member is listed on the pharmacy report. HSD changed the report format and instructions to identify the members' care coordination level in these instances. It has been recommended that the high number of members with prescriptions filled for the same drug class more than three times in a month, who are in care coordination level 1 (members who require the least amount of care coordination), and who could not be contacted by the MCO, must have outreach for a HRA and must be considered for a CNA.

The MCOs must comply with the contractually required care coordination staffing ratios. The care coordinator-to-member ratios vary depending on the care coordination level. HSD monitors the monthly Caseload and Staffing Ratios Report designed to capture the overall care coordinator-to-member ratios. A significant challenge for a MCO is that the ratios change as the HRAs are completed. Each completed HRA results in the assignment of the member to a care coordination level.

HSD holds weekly meetings with MCOs to address care coordination staffing requirements and performs a weekly care coordination staffing analysis. MCOs engage in recruiting activities, hold job fairs, and conduct other activities in order to meet staffing ratios. For example, MCOs have assigned caseloads to care coordination supervisors and managers in order to meet ratios.

Electronic Visit Verification (EVV)

The MCOs continue to collaborate with First Data (vendor) in preparation for the implementation of the EVV system on October 1, 2014. The EVV system initiative is expected to enable greater accuracy in service tracking, reporting, and billing for in-home care providers. The EVV system will allow MCOs and the provider community to better serve Medicaid members and ensure members receive the services they need, while reducing the risk of fraud.

Providers, MCOs, and HSD continue to work together to ensure EVV implementation is seamless and not disruptive to members or caregivers. An EVV pilot began July 1, 2014, with four volunteer pilot providers who continue to beta test the system to ensure its efficiency and accuracy. This partnership is expected to ensure a successful implementation of EVV as well as improve the members' access to care and quality of care. HSD will closely monitor the implementation of the EVV system and allow exceptions for submitting paper timesheets to ensure there are no interruptions in services or delays in payments to providers.

Naloxone Rescue Kits

During the reporting period, HSD added Naloxone rescue kits with nasal atomizers as a Medicaid-covered Pharmaceutical benefit. This allows providers and pharmacists to prescribe the kit, allows pharmacies to be adequately reimbursed for the kit, and provides for Medicaid recipient/family education regarding its use. This was instituted after a DOH pilot project showed a significant decrease in overdose events when Naloxone kits were routinely provided to at-risk persons. The intent is to address, in part, inadvertent overdoses from opioids, whether illicit or prescribed. This includes not only those with known opioid abuse/addiction histories, but also, those on high doses for palliative care, chronic pain, and post-operative patients on opioids. An educational campaign for providers is also being undertaken by the New Mexico Medical Society.

Autism Services

Medicaid services for individuals identified with Autism now include support of applied behavioral analysis under Centennial Care. To better understand and integrate services, HSD will coordinate an oversight team bringing together agencies, providers, experts in the field, and advocates to develop guidance to implement the new service. Currently, many Autism services for children are addressed through Early Periodic Screening, Diagnosis, and Treatment; however, coordinating the array of services for adolescents and adults will be the work of the oversight team.

Behavioral Health

The HSD MAD has a contract manager for each MCO and BHSD has two contract managers who oversee the four MCOs. The MAD and BHSD contract managers collaborate on all MCO issues that involve BH concerns. As part of this collaboration, all contract managers meet monthly to finalize strategic approaches in addressing BH-related issues with the MCOs. In

addition, the contract managers and the HSD/MAD Care Coordination Unit meet weekly to evaluate the performance of each MCO's care coordination efforts and BH integration. MAD and BHSD leadership meet bi-monthly to review and discuss overlapping issues and coordination efforts. The result of these meetings has been increased communication and teamwork when managing MCO issues that affect both divisions. With the goal of health care that coordinates PH and BH, the MAD and BHSD contract managers also work together on member issues.

Prior to January 1, 2014, representatives from the MCO and the 16 CSAs met weekly in preparation for Centennial Care. HSD continues to host bi-weekly meetings as implementation of Centennial Care BH services has required new processes for billing, care coordination, finding unreachable members, and statewide access of BH services. The transition from one MCO to four MCOs has required significant system changes. The opportunity for providers to meet regularly with BH leaders from each MCO is a unique way to build relationships and address problems with new systems changes. The CSAs are also working with the MCOs to reach those members who have difficulty engaging. Other issues discussed in the group include preparation for Diagnostic Services Manual V (DSM-V) for billing, discharge planning and coordination, dissemination of new BH codes, and payment increases.

Bringing together BH providers and representatives from MCOs has been critical in identifying problems and finding solutions during this transition period. The meetings create a venue where operational hurdles can be addressed in a timely manner. In response to feedback from those meetings, HSD is reviewing workforce-related issues, including professional licensing requirements and supervision standards.

Quality of Care
Please refer to Section XIII for information related to quality of care.

Health Plan Contract Compliance and Financial Performance Relevant to the Demonstration
The HSD/MAD Centennial Care Bureau actively monitors all MCOs to ensure contract standards are met. Through this monitoring, all member and provider issues are tracked and addressed.

HSD monitors regularly scheduled, contractually required reports (see Section XIV: Managed Care Reporting Requirements) and also receives notification of issues from providers, members, advocacy groups, and other stakeholders. When these issues rise to the level of a trend or reflect a particularly sensitive issue, HSD requires ad-hoc reports from the MCOs in order to better analyze the identified problems. From the ad-hoc reports, the contract managers synthesize and summarize the responses for HSD leadership to review. See Attachment B for examples of ad-hoc reports requested and received from the MCOs during the second quarter.

In addition to ad-hoc reports, HSD reviews scheduled reporting by the MCOs, as required by the contract (see Section XIV: Managed Care Reporting Requirements). Six months of scheduled reports have now been received, including the second quarter reports received on July 31, 2014. Each report is reviewed by subject matter experts for completeness, accuracy, timeliness, and to

ensure it is meeting contract specified metrics. The contract permits penalties and sanctions for failure to meet any of the contractual reporting requirements.

The following regularly scheduled weekly reports provide for detailed monitoring of performance during the implementation period.

Table 6. Weekly Status Update Ad Hoc Reporting

Number	Name of Report	Purpose
1	CSA Contracting Status	To ensure that each MCO contracted with each approved CSA as required in the Centennial Care contract. CSAs provide the majority of BH services in clinic settings.
2	Provider Network Contracting Status	To ensure the integration of BH and LTC providers in each MCO's provider network and to monitor the progress of each MCO's contracting given the unique challenges for rural and frontier access to care.
3	Care Coordination Staffing Levels	To ensure the adequacy of each MCO's care coordination functions–this is integral to Centennial Care.

Centennial Care financial information remains somewhat limited for several reasons. The first set of comprehensive MCO financial reports were submitted to HSD on August 15, 2014. These reports cover the period from January 1 to June 30, 2014, but full analysis was not completed in time for inclusion in this quarter's report. HSD extended the deadline for these reports due to significant revisions in the reporting templates from pre-Centennial Care programs and to ensure complete and accurate financial data being reported by each MCO.

Fiscal Issues

During this reporting period, HSD continued making MCO payments and completed six months of capitations. HSD made adjustments to the capitation rates at the end of June with a retroactive impact to January. Changes in the rates that were effective January 1, 2014 included: the Centennial Rewards program that incentivizes preventive care and healthy behaviors; the addition of fees and higher budget amounts under the self-directed community benefit; and adjustments to reflect contracts negotiated with BH providers. Base rate increases for qualified Safety Net Care Pool hospitals were effective April 1, 2014.

HSD continues to analyze enrollment data and is now seeing a leveling off of the enrollment in the Parents and Caretakers eligibility group (Population/MEG 1 – TANF and Related). HSD is continuing to watch enrollment shifts closely to be able to predict costs during the first years of the waiver and to determine the overall impact on the Medicaid budget.

Systems Issues

The systems issues that have affected Centennial Care enrollment status have not been solely related to the implementation of Centennial Care but to the interaction of implementing multiple initiatives at the same time. The system issues have been primarily tied to multiple systems interacting with each other and the interfacing of those systems. HSD has diligently worked to coordinate and resolve all system issues when identified.

Pertinent Legislation or Litigation
There was no pertinent legislation or litigation during the second quarter of 2014.

Quality Assurance/Monitoring
Please refer to Section XIII for information related to quality assurance/monitoring.

Section VII: Home and Community Based Services (HCBS)
New Mexico Independent Consumer Support System (NMICSS)
HSD, with assistance through the NMICSS Advisory Team and partnering organizations, is developing tools and data elements for the tracking system that will inform the NMICSS and support the reporting requirements to CMS. The NMICSS continues to recruit and establish a system of organizations that provide standardized information to beneficiaries about Centennial Care, long-term services and supports (LTSS), the MCO grievance and appeals process, and the fair hearing process.

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

ADRC coordinators provide over-the-phone counseling through care coordination, which is the process for assisting the client in describing their situation/problem. ADRC staff offers options, coordinates New Mexico's aging and disability service systems, provides objective information and assistance, and empowers people to make informed decisions. The ALTSD provides quarterly reports to HSD regarding the ADRC Caller Profile Report and Care Transitions Program Data.

The numbers below reflect calls made to the ADRC hotline from April 1 to June 30, 2014.

Table 7. ADRC Call Profiler Report

Topic	# of Calls
Home/Community-based Care Waiver Programs	2,412
LTC/Case Management	89
Medicaid Appeals/Complaints	107
Personal Care	54
Transitional Case/Care Management	167

Listed below are examples of the nature of the calls the ADRC toll-free telephone number receives by topic.

Home/Community-based Care Waiver Programs
- Centennial Care Waiver Community Benefit Registry.
- Requests for Expedited Registry.
- LTSS information and available options.
- Assistance and counseling for community reintegration.
- Assist NF staff with patient transitions.
- Referrals to ADRC care transition team.

- Referrals for Centennial Care options counseling.
- Referrals to LTC Ombudsman.

Long Term Case/Care Management
- Provide assistance and referral to programs that assist in planning and arranging for services.
- Provide counseling and assistance with LTC care plans.
- Assist with education and referrals to NF care.

Medicaid Appeals/Complaints
- Assist with understanding Centennial Care grievance and appeals process.
- Referrals to MCOs for filing grievance and appeals.
- Referrals to advocacy organizations and legal services for fair hearings with HSD.
- Referrals to LTC Ombudsman.

Personal Care
- Education and referrals for personal care services.
- Education and assistance in understanding activities of daily living (ADLs).

Transitional Case/Care Management
- Assist with transitions from hospitalization to independent living.
- Assistance to obtain and coordinate the support services needed during transition.

To enhance the ADRCs call profiler reporting and to assist the NMICSS data collection effective July 1, 2014, the ADRC added new topics to its Call Profiler Reporting. Listed below are the ADRC's new topic definitions:

Medicaid Information/Counseling
- Programs that offer information and guidance for people who may qualify for Medicaid, including those who do not have access to insurance provided by an employer, cannot afford privately purchased health insurance, or cannot afford the out-of-pocket costs associated with a health insurance plan they may have in place. Included may be information about the eligibility requirements for Medicaid and how to apply; Medicaid Managed Care options including benefits covered (and not covered) by the program; the payment process for co-payments; Medicaid "spend-down" (the process of reducing the assets an individual possesses in order to qualify for Medicaid); and information about Medicare and the linkages between the two programs. The program may also answer questions about Medicaid services available to individuals with disabilities; and some programs may help people who qualify with enrollment and provide referrals to providers who accept Medicaid.

Medicaid Managed Care Enrollment Programs
- State programs (or private vendors under contract with the State) that enroll Medicaid recipients in a Medicaid Managed Care program that coordinates the provision, quality, and cost of care for its enrolled members. Recipients may have a designated amount of time to choose a managed care option following eligibility determination, and once enrolled, select a primary care practitioner from the plan's network of professionals and hospitals who will be responsible for coordinating their health care and referring them to specialists or other health

care providers, as necessary. In some situations, where acute and primary care are not integrated into the selected option, people may work with a multidisciplinary team of professionals to support service plan development and implementation. Enrollment in a managed care plan may be voluntary or mandatory for some or all Medicaid recipients in a state. Participation requirements and associated criteria vary from state to state and in some cases, from area to area within the same state. States often make exceptions to their mandatory enrollment requirements for certain individuals and groups (e.g., people with disabilities or identified health conditions), which may be served outside the state's managed care delivery system. These individuals may enroll in a managed care program but are not required to do so. States may also identify a range of MEGs who are excluded from participating in their managed care programs. Also included are other programs that help people prepare and file State Medicaid Managed Care enrollment applications.

Medicaid Waiver Appeals/Complaints

- Programs that are responsible for hearing appeals and resolving complaints that have been filed by people who have applied for or are receiving benefits through a Medicaid waiver program, and believe that they have been discriminated against, that their rights have been violated, or that the program has failed to take appropriate action with respect to their application or benefits. The program also hears appeals by providers seeking to participate in the program whose applications have been denied.

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

Table 8. ADRC Care Transition Program Report

Counseling Services	# of hours	# of Nursing Home Residents	# of Contacts
Transition Advocacy Support Services		79	
Medicaid Education/Outreach	576		
Medicaid Options/Enrollment	270		
Pre/Post Transition Follow-up Contact			*956

* Note: Eighty-eight percent (88%) of the contacts are pre-transition contacts and the remaining twelve percent (12%) are post transition contacts. These numbers are resident specific and situation dependent.

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

- The Care Transition Bureau received transition referrals through the ADRC Call Center beginning on April 1, 2014. This dramatically increased the awareness of the service, and subsequently increased the caseload amounts statewide. The total number of residents served in this SFY fourth quarter doubled since the previous SFY third quarter.
- An additional care transition specialist was added to the program as a full-time employee (FTE) during SFY fourth quarter to accommodate the increase in referrals.
- The care transition program now serves individuals who have transitioned from NFs back into the community but who have lost Medicaid eligibility for a variety of reasons and are in need of assistance in re-establishing those benefits.
- The increase in individuals potentially eligible for Medicaid since the roll out of the ACA and New Mexico's Centennial Care Program.

HSD will have access to more data for third and fourth quarter reporting that will assist in understanding the types of questions and issues Centennial Care members may have when utilizing LTSS, and in considering whether the NMICSS is meeting its intended purpose. The San Juan Center for Independence and the Brain Injury Resource Center at the Center for Development and Disability are the newest partners with the NMICSS and will provide data in future reporting. The Medicaid Call Center added data elements to the existing call tracking system that will contribute to increasing data collection.

Critical Incidents

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

- Ongoing bi-weekly meetings continue with the MCOs and HSD to discuss issues and concerns about the process. Issues addressed this quarter included clarifying direction for BH providers. BH providers requested clarification on which of the providers are responsible for reporting incidents into the HSD critical incident website. The critical incident reporting (CIR) workgroup includes representation from BHSD and discussion led to the decision that provider groups and facilities will use the portal and others would continue to report to Adult Protective Services (APS) and Child Protective Services without the additional requirement to report directly to the MCOs. Further discussion will further define BH providers within the groups and facilities.
- Daily review is conducted by HSD staff of all incidents submitted. Improvements have been noted in the quality of reporting by providers and the documentation of follow up by the MCOs. HSD continues to direct the MCOs to provide technical assistance when providers are non-compliant.
- Bi-weekly aggregated reports of concerns are emailed to each MCO. The MCOs respond with sufficient information to assure HSD that the MCOs and agencies are doing due diligence. In this quarter, UHC had a significantly larger list of corrections and concerns. HSD then required an intensive four week review of all incidents submitted by UHC with weekly telephone conferences to review each concern. The result has been improved performance and continued monitoring.
- A quarterly review of all deaths submitted into the HSD critical incident web portal is conducted. The three homicides and one suicide reported in the first quarter did not occur under the care of a provider, meaning they did not occur while Centennial Care services were being delivered or while in the care of a facility. Investigations were initiated by appropriate agencies according to State requirements. In the second quarter there were three unexpected deaths that occurred during authorized hours. One member died after keeping a physician appointment and returning home. One member died on the way to a physician appointment and one member fell, hit his head and died while emergency services were transporting him to the hospital. All three of these deaths are under review by the MCO quality of care departments. In all cases the caregiver responded quickly and appropriately. There was one homicide and no suicides reported. The homicide did not occur during authorized service hours.
- An analysis of the opportunities for improving systems and preventing future harm will be included in the future quarterly reports.

- On a daily basis, HSD staff manages user access and other operations of the data base, including password creation or resetting, troubleshooting application issues, deleting duplicate reports and other tasks.
- Ongoing collaboration continues with the HSD/BHSD, and the HSD/MAD Centennial Care Bureau to address individual and system/program issues.
- The HSD Critical Incident Unit shares information with other HSD staff when a system issue is identified with an MCO or with care coordination. One example is an incident identifying that a member had transitioned from a hospital and was not receiving the personal care services she needed. By working with HSD enrollment staff, an eligibility issue was resolved and her care coordinator was able to authorize the needed services.

Currently, the web-based system supports over 1,500 users statewide.

Table 9. Critical Incidents — Primary Incident Type: Quarter 2 Report

Critical Incident Types	Centennial Care	Centennial Care % per Incident Type	BH	BH % per Incident Type	Self-Directed Community Benefit (SDCB)	SDCB % per Incident Type
Abuse	261	12%	83	38%	21	10%
Neglect	179	8%	16	7%	17	8%
Exploitation	94	4%	2	1%	16	7%
Environmental Hazard	39	2%	3	1%	1	0%
Emergency Services	1224	57%	63	29%	132	61%
Law Enforcement	94	4%	27	13%	7	3%
Elopement/ Missing	25	1%	14	6%	2	1%
Deaths						
Natural/ Expected	192	9%	6	3%	19	9%
Unexpected	39	2%	2	1%	1	0%
Homicide	1	0%	0	0%	0	0%
Suicide	0	0%	0	0%	0	0%
Total Number of Critical Incidents	**2148**	**100%**	**216**	**100%**	**216**	**100%**

The CIR system has the capacity to identify members with multiple reports. By pulling reports of members with more than two critical incidents in a month, HSD can determine if there is an opportunity to look more closely at services. This is true for reports of other incident types, as well. There have been several instances where multiple reports have triggered visits by the care coordinator and collaboration with the service agency to resolve issues. One member had multiple reports involving family members threatening her, stealing her medications, and not

allowing care to be delivered. The care coordinator and the agency worked to find her another place to live and increased her authorized hours to reflect lack of appropriate family assistance. The investigations by APS were able to support her allegations but timely resolution did not depend on a complete investigation. A CIR project that clarified that agencies were to report incidents even if they did not occur during authorized hours has allowed a more effective communication of member issues to care coordination. This was the result of creating a selection in the web form for "not during authorized hours" which enabled the agencies to report without fearing they would be responsible for something they did not control. Now if a member is frequently calling the EMS after the caregiver leaves, the MCO has a clearer picture of the member's needs and can better target his/her services.

Participant Access and Eligibility
Please refer to Section II for information on access to LTC services. There are no HCBS eligibility issues to report in this quarter.

Self-Directed Community Benefit
As of June 26, 2014, the SDCB population consisted of 940 members. May 1, 2014, was the 121st day of Centennial Care and the first day that Agency-Based Community Benefit (ABCB) members were eligible to switch to SDCB. Each MCO began working with existing ABCB members to transition ABCB members who requested SDCB.

Quality assurance monitoring activities in the quarter included working with members, care coordinators, and support brokers to address issues and concerns related to the four services that did not carry over from Mi Via to SDCB. These services are: assisted living services, community direct support/navigation, personal plan facilitation, and customized in-home living supports. Efforts continue with various entities related to unexpected changes in eligibility due to ASPEN issues, SOC coding and active/inactive status in the FOCoS online system that supports the SDCB. HSD continues to monitor MCO progress with transitioning members who had assisted living as an approved service in Mi Via, and must make the decision to remain in SDCB without the assisted living service in their SDCB care plans or transition to ABCB.

SDCB staff has recognized that support brokers and care coordinators are experiencing various issues related to the following: how and when to add a member to the FOCoS online system to allow the support broker to begin developing the SDCB care plan with the member; SDCB budget determination; and support broker versus care coordinator responsibilities. To address these issues, HSD SDCB staff developed an in-depth SDCB training for all support brokers and care coordinators that was conducted on Tuesday, August 12, 2014. Outcomes will be reported in the third quarter.

Provider Credentialing
Each quarter, and when new providers are approved by HSD, HSD sends the MCOs a current list of approved ABCB providers to ensure the MCOs only contract with providers who have been credentialed or re-credentialed by HSD. Additionally, HSD analyzes and monitors the number of providers for the entire Centennial Care program through the quarterly Network Adequacy Report and a quarterly ad-hoc report that lists the ABCB providers for each MCO.

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

Section VIII: American Indian/Alaska Native Reporting

Access to Care

Please refer to Section II for information on access to care.

Contracting Between MCOs and I/T/U Providers

In the reporting period, several MCOs contracted with Pine Hill Health Center. Zuni Medical Supply, Five Sandoval Indian Pueblos Inc., Santo Domingo Clinic, and Alamo/Navajo Health Center are in the process of contracting with the MCOs.

Ensuring Timely Payment for All I/T/U Providers

All four MCOs met timely payment requirements ranging from 90% to 97% of claims being processed and paid timely.

Table 10: Issues Identified and Recommendations Made by the Native American Advisory Board (NAAB) and the Native American Technical Advisory Committee (NATAC)

MCO	Date of Board Meeting	Issues/Recommendations
BCBS	Gallup, NM 5/03/14	Low attendance, no issues/recommendations. BCBS changed the meeting to Saturday in an attempt to have more attendance. This was not successful, so the meeting will be moved back to a weekday.
Molina	Albuquerque, NM 06/04/14	Attendees requested more information from Molina. Molina will inform providers of program changes, improvements and how the MCO will report resolution back to the NAAB.
	Gallup, NM 05/02/14	Members requested that an additional meeting be held in this location later this year.
PHP	Gallup, NM 06/13/14	Navajo Nation community health representatives and PHP will work together on a plan for completing HRAs and CNAs.
UHC	Tohajiilee, NM 06/04/14	UHC will connect Tribal BH with their BH specialists/contractors. UHC will provide billing/claims training for Tribal BH providers. Opportunities for telemedicine were discussed.

The NATAC meeting for this reporting period was held on April 28, 2014. Eleven members were present. The meeting included discussion on current Centennial Care enrollment numbers for Native Americans; the number of Native Americans in an MCO versus FFS; and timeliness of claims reimbursement. The committee asked the Medicaid Tribal liaison to provide more information to I/T/Us about the Centennial Rewards program at the next NATAC meeting.

Section IX: Action Plans for Addressing any Issues Identified

CMS had several questions from the first quarter report concerning action plans. In response, HSD notes that there is no difference between "unreachable" members and "unable to contact" members. Also, in response to another question, HSD notes that Molina served as the third party assessor for the CoLTS program and, in this capacity, provided NFLOC determinations. Molina did not provide LTC services under the Salud! program. Molina has indicated resolution of its first quarter NFLOC backlog in its status update below.

The following action plans were recommended to the MCOs after HSD identification of issues and discussions with the MCOs, so that HSD can monitor MCO internal issues. For this second quarter report, the MCOs have updated information in their internal action plans. The first section lists action plans opened in the first quarter that were either closed in the second quarter or later, or are still ongoing. The second section lists actions plans that were opened in the second quarter. Please note that HSD has not imposed any formal CAPs or directed corrective action plans (DCAPs) on the MCOs during this reporting period.

Quarter 1 FY14

BCBS

Q1FY14

Action Plan #1	Implementation Date	Completion Date
Unreachable Members	3/10/14	4/15/14

Description

Based on lists of unreachable members submitted by all MCOs, HSD staff attempted to contact 25 members per week from each MCO for four consecutive weeks. HSD and BCBS have plans to conduct innovative campaigns that include booths at public spaces, member rewards for completing HRAs, and coordinating with Income Support Division, school-based clinics and other State agencies to facilitate reaching unreachable members. HSD has shared all enrollment files with the MCOs and has closely monitored the MCOs' activities towards decreasing the number of unreachable members.

Status

In an effort to decrease the number of unreachable members, community health workers (CHWs) and CSAs were engaged to assist with field HRA activities. Collaboration has also taken place with PCS agencies. BCBS also implemented a process to review claim information to assist in contacting/locating unreachable members.

BCBS

Q1FY14

Action Plan #2	Implementation Date	Completion Date
UM Intake Line	2/14/14	7/9/14

Description

Increase percentage of calls answered within 30 seconds for UM intake during Centennial Care start up by optimizing schedules, reviewing customer advocate activities during peak call hours, and increasing the number of employees.

Status

All call center metrics were met for UM intake in the month of May.

BCBS

Q1FY14

Action Plan #3	Implementation Date	Completion Date
Provider Tri-County	2/25/14	7/9/14

Description

Tri-County reported that it was experiencing claims payment issues. HSD held weekly meetings for five weeks until the issues were resolved. HSD now touches base with the provider on an as needed basis.

Status

This process improvement has proved to be effective as the provider has not reported recent claims issues.

BCBS

Q1FY14

Action Plan #4	Implementation Date	Completion Date
CNA Revision	3/6/14	On-going

Description

Revisions were made to the CNA template to facilitate a better member experience and to maximize efficiencies.

Status

HSD is continuing to monitor the outcomes of this process improvement.

BCBS

Q1FY14

Action Plan #5	Implementation Date	Completion Date
PCP Auto-Assignment	3/18/14	Ongoing

Description

Correction to PCP auto-assignment logic to allow members 15 days to select a PCP prior to being auto assigned.

Status

HSD is continuing to monitor the outcomes of this process improvement.

BCBS

Q1FY14

Action Plan #6	Implementation Date	Completion Date
Community Benefit Services Plan Monitoring	3/25/2014	Ongoing

Description

A plan was developed to improve community benefit services plans by ensuring all care plan goals and safety and health needs were met. System issues and barriers were identified and mitigated and a quality assurance process was implemented.

Status

HSD continues to explore the possibility of an auto-calculated allocation tool. This will decrease human error and have a positive impact overall with care coordination and utilization management as well as addressing specific system barriers as stated in the action plan.

UHC

Q1FY14

Action Plan #7	Implementation Date	Completion Date
PCP Auto-Assignment Changes	1/3/2014	10/15/14

Description

Change/delay PCP auto-assignment process until the 16th day from eligibility load date for newly effective members who have not selected a PCP and exclude Native American members from PCP auto-assignment process.

Status

UHC developed a process with the Hospitality, Assessment and Retention Center (HARC). HARC conducts an initial call within five days of the member's enrollment and determines if the PCP assignment is acceptable to the member and if not, UHC assists the member in selecting a new PCP. The HARC will continue this process until 10/15/14.

UHC

Q1FY14

Action Plan #8	Implementation Date	Completion Date
HRA Completion	3/1/2014	5/2/14

Description

Increase member HRA completion rate for care coordination level 1 members by 3%.

Status

Outreach attempts made via auto-dialer and external vendor to provide extra demographic data. UHC increased the HRA completion rate for level 1 members by 3% in May 2014.

UHC

Q1FY14

Action Plan #9	Implementation Date	Completion Date
NFLOC Backlog	3/31/2014; restarted project 07/25/2014	5/30/14; restarted project; end date 09/05/2014

Description

Identified NF members who have not had a LOC determination for an initial or continued stay.

Status

Project was completed and was restarted on July 25, 2014. Initial project was to provide additional training to NFs on packet submissions and NFLOC process. Project has been restarted to address backlog of NFLOC determinations due to unanticipated volumes and reconciliation of SOC discrepancies. There has not been any identified impact on care and services for UHC NF membership during this clean-up process. Current and active NF members are approximately 1,800. As of March 31, 2014, NFLOC determinations were needed of the approximate 1,800 NF members. This did not impact members' access to services. As of July 25, 2014, there were an estimated 10% (180) of the 1,800 due for NFLOC determination. The project was restarted for reconciliation purposes to assure timely decisions. UHC continues to provide education/technical assistance to identified NFs regarding packet submission process.

Molina

Q1FY14

Action Plan #10	Implementation Date	Completion Date
Unreachable Members	2/27/2014	Ongoing

Description

Unable to contact/unreachable members.

Status

UNM, ITM, ABQ Health Partners, First Choice, and San Juan IPA provided lists of members to assist with locating membership in February 2014. Peer support specialists partnered with homeless shelters to outreach to membership starting in mid-January. All unreachable members

are referred to the CHW program to locate the member in their community. Molina hired six additional CHWs to complete outreach to membership defined as unreachable. The CHW program locates and completes on average 400 HRAs each month on previously identified unreachable membership. A dedicated team was developed to review claims activity and contact providers to obtain updated contact information and find unreachable members. A corporate vendor was deployed in May to make three additional outreach attempts to previously identified unreachable members. Care coordinators continue to partner with personal care service agencies, IHS, CSAs and other providers to locate unreachable membership. Announcements were made at winter and spring New Mexico Hospital & Health Association meetings with a request for providers to encourage members to contact care coordinators. The care coordination unit phone number was provided at each meeting. A health fair was conducted in May at Lovelace Women's Hospital with postcards sent to all previously identified unreachable members. Twenty-five members were assessed during that event. Overall there has not been a decrease in unreachable membership.

Molina

Q1FY14

Action Plan #11	Implementation Date	Completion Date
HRA Completion	1/10/2014	Ongoing. Initial goal met on 04/30/14

Description

Increase number of completed HRAs.

Status

Molina used a corporate vendor to assist with completion of the HRAs. The corporate vendor was deployed to assist beginning in January. Molina initiated increased monitoring by requiring staff to report HRA completion results three times per day to upper management.

Molina initiated an alternate 10-7 p.m. work shift in January (including Saturdays) to increase contact percentage rate. HRAs were conducted in CSAs in January by CHWs. In March, HRA completion total was 10,760. In April, the total HRAs completed increased to 11,787, and in May the total HRAs completed increased to 13,248. This represented a 10% improvement from March to April in HRA completion and 12% improvement in HRA completion from April to May 2014.

Molina

Q1FY14

Action Plan #12	Implementation Date	Completion Date
CNA Completion	1/13/2014	Ongoing. Initial goal met on 02/28/14.

Description

Increase number of CNAs to meet contractual deadlines.

Status

In March, Molina held job fairs in Albuquerque, Farmington, and Gallup. Alternate weekend shifts were initiated to increase accessibility to members. Molina created a dedicated scheduling team to assist with scheduling CNAs. There was a 73% quarter-over-quarter CNA completion improvement with a January total of 568 CNAs completed, and a total for June of 2,306 CNAs completed.

Molina

Q1FY14

Action Plan #13	Implementation Date	Completion Date
PA	1/14/2014	Ongoing. Initial goal met on 1/30/2014.

Description

Reduce duplication of PAs to validate the Daily Transition Report.

Status

Process created to manually track all incoming PA requests and all faxes daily. The purpose of this process is to document and eradicate duplicate PA requests. Daily manual tracking reduced duplication by approximately 30%. Average turnaround time is three to four days for PA and concurrent review.

Molina

Q1FY14

Action Plan #14	Implementation Date	Completion Date
Expired/Expiring NFLOCs	1/24/2014	Ongoing. Initial goal met 02/28/14.

Description

Address high number of expired NFLOCs.

Status

Molina developed a NFLOC tracking process to prioritize and track the CNA and care plan completion on those members who had an expiring or expired NFLOCs. In January, there was a total of 3,025 NFLOCs expiring or expired with a decrease in the total in February to 1,021 NFLOCs expiring or expired — representing a 66% decrease from the previous month. In March, total NFLOCs expiring or expired decreased to a total of 314 representing a 69% decrease. In April, the total NFLOCs expiring or expired was 306 representing a 3% decrease from the previous month. Quarter-over-quarter, there was a 64% decrease in NFLOCs expiring or expired.

Molina

Q1FY14

Action Plan #15	Implementation Date	Completion Date
Additional Staffing Plan	2/11/2014	Ongoing. Initial goal met on 6/30/14.

Description

Increase staffing to meet contractual guidelines for staffing ratios.

Status

Molina increased planned number of staff to be hired in February to 130. By the end of March, 54 more care coordinators were hired for a 16% increase from February to March in staffing. In April, 14 additional care coordinators were hired representing a 4% increase in staff from March to April. In May, 16 additional care coordinators were hired representing a 17% increase in staff from April to May. In June, six additional care coordinators were hired representing a 1% increase from May to June. A total of 143 additional care coordinators were hired for a 41% increase in staffing from January 2014.

Molina

Q1FY14

Action Plan #16	Implementation Date	Completion Date
HRA Completion Transitioning Members	2/27/2014	Ongoing. Initial goal met 3/30/14.

Description

Address completion of HRAs and CNAs for transitioning members.

Status

Molina implemented a process and increased hiring events to improve outcomes of HRA completion percentage. A dedicated tracker team was created to assist with reminders to care coordinators of HRAs needing completion to assist with prioritization. Supervisors and managers assisted with outbound calls to increase contacts and improve overall HRA completion for transitioning members. A corporate vendor was deployed to assist with outreach calls to members. Molina increased the total HRAs completed from 9,795 in February to 10,393 in March. A total of 10,869 HRAs were completed in May 2014 exceeding totals from February and March.

Molina

Q1FY14

Action Plan #17	Implementation Date	Completion Date
Claims Turnaround Time	3/26/2014	Ongoing. Initial goal met 1/30/14

Description

Improve claims turnaround time for I/T/Us, day activity providers, assisted living providers, NFs and home care agencies, including community benefit providers.

Status

A UM claims team of six FTEs was created to track and process claims within 15 day turnaround time.

PHP

Q1FY14

Action Plan #18	Implementation Date	Completion Date
HRA	1/29/2014	6/8/14

Description

Align internal resources to support HSD Transition Report data requirements driven by HSD Transition Report instructions. PHP engaged an HRA vendor to augment its internal resources and ensure compliance with HRA contractual requirements. The vendor will begin executing HRA call campaigns; systems and processes will be aligned to ensure data integrity and reporting accuracy.

Status

HSD is continuing to monitor the outcomes of this process improvement.

Quarter 2 FY14

BCBS

Q2FY14

Action Plan #1	Implementation Date	Completion Date
Reduction in Care Requests	4/14/14	Ongoing

Description

A review of the process and criteria was conducted to ensure that reduction in care requests submitted for approval were appropriate and had all the desired data elements. Steps were implemented to ensure submissions were in alignment with HSD criteria.

Status

HSD is continuing to monitor the outcomes of this process improvement.

BCBS

Q2FY14

Action Plan #2	Implementation Date	Completion Date
Member Services Voice Mail Call Returns	4/24/14	7/9/14

Description

A certification process was developed to ensure that all voicemails left for member services are returned by the next business day.

Status

Since the implementation of this intervention, all voicemails have been returned the next business day.

BCBS

Q2FY14

Action Plan #3	Implementation Date	Completion Date
Replacement Member Materials	5/9/14	Ongoing

Description

A review of the enrollment software was conducted to identify cases where replacement materials were not being triggered. Updates were made and quality assurance steps were implemented to meet the 10 day mailing requirement.

Status

HSD is continuing to monitor the outcomes of this process improvement.

BCBS

Q2FY14

Action Plan #4	Implementation Date	Completion Date
NFLOC Faxes	5/16/14	7/9/14

Description

A review of the fax interface with the network provider to ensure that NFLOC requests are received and processed timely. A team tested the fax process with the provider and identified a barrier, which was remediated.

Status

This correction has proven to be effective; there have been no further reports of faxes not being received.

BCBS

Q2FY14

Action Plan #5	Implementation Date	Completion Date
DOH Claims	6/23/14	Ongoing

Description

BCBS has provided outreach to all DOH facilities in order to ensure all of their claims are processing accurately and timely. These outreach efforts have proven to be effective as they have strengthened the MCOs' relationships with these entities by building trust and providing them with all needed resources/tools for any questions they may have.

Status

HSD is continuing to monitor the outcomes of this process improvement.

BCBS

Q2FY14

Action Plan #6	Implementation Date	Completion Date
Native American Advisory Board Meetings	6/1/14	Ongoing

Description

Issue: BCBS would like to increase member participation during the Native American advisory board meetings. BCBS's observations from previous meetings are that the attending agencies were very active in the meeting and members became disengaged. The tribal liaisons are updating their strategy to hold future meetings during the week and exploring the idea to divide the meeting into sections for members and for providers to allow greater participation.

Status

HSD is continuing to monitor the outcomes of this process improvement.

BCBS

Q2FY14

Action Plan #7	Implementation Date	Completion Date
Claims Processing Accuracy	4/15/14	Ongoing

Description

During the first quarter reporting period, error codes were cited in six of the 14 HSD defined categories. To help improve accuracy, BCBS has done the following:

1. Staffing education is conducted for all areas of findings that have been cited:
   A. Ongoing training is being conducted as additional opportunities are identified.
   B. Documentation is updated and distributed to the staff when identified.
   C. Individual feedback is provided to the operators to confirm understanding.

D. Claims are being distributed to individuals based on expertise and understanding of claim complexity.

2. Pricing Errors — Provider networking has been updating the pricing system according to pricing agreements. Claims are routed to them for pricing confirmation when the system has not been updated.
3. Policy Violations — Staffing additions and optimizations have been employed including:
   A. Optimization of workflows.
   B. Working overtime hours.
   C. Systematic fixes to issues continue to be pursued, improving timeliness.
4. Remaining Findings — Feedback was provided to the individual operators and we continue to monitor for any developing trends.

Status

HSD is continuing to monitor the outcomes of this process improvement.

UHC

Q2FY14

Action Plan #8	Implementation Date	Completion Date
I/T/U OMB Rate Changes	4/9/14	7/31/14

Description

Update 2014 OMB rates in claims system and process adjustments for 2014 dates of services already processed.

Status

This was completed the first week of July. There were 32 providers impacted. There were a total of 1,950 claims adjusted in the amount of $43,915.00.

UHC

Q2FY14

Action Plan #9	Implementation Date	Completion Date
Vision Care Recruitment Action Plan	5/8/14	9/1/14

Description

Action plan to alleviate service provider gaps caused by loss of Walmart vision centers. Grant County is the primary focus with at least one of three providers verbally committed to a contract.

Status

There were 1,263 members impacted by the loss of Walmart vision. UHC has since contracted with Dr. Jason Bracher.

UHC

Q2FY14

Action Plan #10	Implementation Date	Completion Date
CNP/CNS BH Provider Loading	5/1/14	8/15/2014

Description

Update BH fee schedules to include appropriate payment of CNP/CNS providers. Providers are on target for loading and completion of all fee schedules as of 7/1/14.

Status:

In progress. HSD changed the completion date from 07/31/2014 to 08/15/2014. There have been 2,241 providers out of 2,315 loaded.

UHC

Q2FY14

Action Plan #11	Implementation Date	Completion Date
Marketplace Postcard Incident	4/16/14	Ongoing

Description

Update print and fulfillment policies and procedures for mailing processes and approvals of mailing materials to ensure that no protected health information is printed on postcards or mailing labels, and is not visible through windowed envelopes.

Status

HSD is continuing to monitor the outcomes of this process improvement.

PHP

Q2FY14

Action Plan #12	Implementation Date	Completion Date
CNA and Care Plans (CP) CAP	5/1/2014	Expected completion 9/30/14

Description

Ensure processes meet regulatory requirements and timeframes.

Status

Completed root cause analysis, process review for CNAs and CPs, validation of reporting requirements care manager (C4C), and validation of SOC requirements.

Planning to implement enhanced SOC identifiers and processes, enhanced level of care management and processes, additional operational reporting, which supports contractual reporting and care manager Phase 1.1b enhanced functionality (final delivery date 12/31/14).

PHP

Q2FY14

Action Plan #13	Implementation Date	Completion Date
HRA	5/1/2014	Expected completion 9/30/14

Description

Ensure processes meet regulatory requirements and timeframes.

Status:

Completed root cause analysis, process review for HRAs, validation of reporting requirements care manager (C4C), and care manager phase 1.1a enhanced functionality.

Planning to implement new contract requirements with HRA vendor (may choose new vendor), implement enhanced operational reporting, and fully execute unreachable member strategies, as documented on our unreachable members plan, approved by HSD.

UHC

Q2FY14

Action Plan #14	Implementation Date	Completion Date
Unreachable Members	7/1/14	Expected completion 9/30/14

Status

Completed root cause analysis for unreachable members. Process review, identification of channels to capture HRAs (i.e., in-bound call flow), and workflow enhancements. Implemented new HRA, with a focus on increasing HRA take rate (decreasing refusals). Implemented monitoring control reports and validation process for HRA disposition results.

Planning to fully execute unreachable member strategies, as documented on unreachable members plan as approved by HSD and full engagement of provider networks to assist in HRA completion (e.g., CSAs, Presbyterian's Medical Group, trading partners, etc.) Planning to implement process to update member contact information from Pharmacy claims, trading partners (e.g., transportation vendor, etc.) and conduct additional outreach campaigns.

PHP

Q1FY14

Action Plan #15	Implementation Date	Completion Date
Unreachable Members	7/1/2014	9/1/2014

Description

Ensure that unreachable member numbers are reduced by 9/1/2014.

Status

CAP in process. Details will be submitted in next quarterly report.

Section X: Financial/Budget Neutrality Development/Issues

The MCOs submitted their first set of comprehensive financial reports to HSD on August 15, 2014. These reports will contain first quarter financial information and as requested by HSD, and year-to-date information on the second quarter. HSD and the MCOs took additional time to ensure that the logic and instructions for each report were clear for both parties and therefore the due dates were extended for these reports. HSD continues to receive encounter data from the MCOs but still does not have a complete set of encounter data for either the first or second quarter of CY 2014. For these reasons, financial reporting for this quarter continues to be limited. HSD expects additional financial data to be analyzed and available for the third quarter report.

HSD continues to observe eligibility and enrollment changes with the roll-out of ASPEN, HSD's new eligibility system. The level of retroactive enrollment has begun to slow down as HSD has processed nearly all outstanding applications from the first quarter. These initial programmatic transitions may impact the variance between quarter-to-quarter expenditures but should not have an impact on overall expenditure reporting or budget neutrality.

As noted in this section for our first quarter submission, HSD is continuing to monitor, create, and revise reports for successful Section 1115 demonstration reporting. HSD found, while continuing to review the expenditures by MEG on the CMS-64, two populations' expenditures were being posted to the wrong MEG. Individuals who are in the Developmentally Disabled and Medically Fragile waivers will have their acute care expenditures shifted from MEGs 4 and 5 to MEGs 2 and 3. Given the timing of producing the SFY14 third quarter CMS-64 report, this change will not appear until the fourth quarter report, at which time all quarters in the calendar year will be revised. For the member month reporting in Section XI of this report, these individuals will be correctly reported in MEGs 2 and 3. Therefore, the budget neutrality table for April 1, 2014—June 30, 2014 (Attachment A) will be out of alignment for MEGs 2 through 5 until next quarter's report.

Section XI: Member Month Reporting

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

Table 11: Member Months

Eligibility Group	Member Month
Population 1 – TANF and Related	1,101,074
Population 2 – SSI and Related — Medicaid Only	122,631
Population 3 – SSI and Related — Dual	104,563
Population 4 – 217-like Group — Medicaid Only	606
Population 5 – 217-like Group — Dual	6,721
Population 6 – VIII Group (expansion)	444,261
Total	**1,779,856**

Section XII: Consumer Issues

A total of 631 member grievances were filed by all four MCOs' members in the second quarter. The non-emergency ground transportation benefit constituted the largest number with 209 (55%) out of 379 of the top three grievances filed. BCBS and UHC reported the largest number of transportation grievances. Both MCOs continue to take additional steps to resolve and decrease the number of transportation issues members are experiencing by working closely with each of their respective transportation vendors. MCOs increased monitoring actions with their contracted transportation vendors, which yielded varied results across the MCOs during this reporting period. Routine, specialty, and community benefit concerns constituted less than 7% of the reported grievances and urgent concerns constituted 3% of the concerns filed. Grievances ranged in nature from dissatisfaction with emergency room staff, long emergency room wait times, lack of same-day appointment availability for specialists, dental issues around eligibility for braces, and some concerns related to vision benefit limits. No significant trends were evidenced in the approximate additional 35% of grievances reported this quarter which varied in type and nature.

The appeals and fair hearings of LTC members, including AIDS, Brain Injury, Disabled and Elderly (aged, blind, and disabled), Medically Fragile, and Developmentally Disabled, were reviewed within the reporting period to assure continuity and access of services and care in meeting the needs of these members. For this reporting period, the LTC members receiving community benefits filed 46 (7%) out of 631 reported grievances. The primary grievance filed by LTC members was also related to transportation comprising 21 (46%) out of 47 of the total grievances filed by LTC members.

Table 12. Q2 Grievances of LTC Members

Top 3 Types of Grievances	# of Grievances by LTC Members	% of LTC Grievances in Relation to Total Grievances (631) by All Members
Transportation Ground Non-Emergency	21	46%
Durable Medical Equipment (DME)	8	17%
Provider Specialist	6	13%
Total LTC Member reported Grievances in Q2	**46**	**7%**

Section XIII: Quality Assurance/Monitoring Activity

Service Plans

The HSD/MAD Quality Bureau (QB) reviewed all service plan reduction requests for the first six months of Centennial Care. The MCOs must submit all service plan reduction proposals to the QB for review and approval before any reductions can take place. During this reporting period, no reductions in service plans occurred.

The QB will continue to conduct random annual service plan reduction reviews to ensure that the MCOs are consistently using approved tools to determine members' services, and are following the process for assessing members' needs. The review of service plans also ensures that the MCOs are appropriately allocating time and implementing the services identified in each member's CNA, and that the member's goals are identified in the care plan.

Nursing Facility Level of Care

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

During this reporting period, 250 NFLOC determinations were reviewed by the EQRO. The emphasis of the review was to ensure the correct process and tools were used to make NFLOC determinations. The correct process includes physician review for denials and downgrades, and the correct tools include the NFLOC criteria and protocol. The QB gives the MCOs technical assistance and direction based on concerns identified by the EQRO.

During this reporting period the QB reviewed 42 high NFLOC denials (downgrades to low NFLOC) and 53 denials of community benefit services. The QB agreed with all MCO determinations. Please see the tables below for additional information on the QB audits of NFLOCs.

Table 13. 2014 NFLOC Denial Audits

High NFLOC Denied Requests (Including Requests that were Downgraded to Low NFLOC)	**Quarter 1**	**Quarter 2**
# of member files audited	31	42
# of member files that met the appropriate level of care criteria	31	42
% of MCO level of care determination accuracy	100%	100%
Community Benefit Denied Requests	**Quarter 1**	**Quarter 2**
# of member files audited	36	53
# of member files that met the appropriate level of care criteria	36	53
% of MCO level of care determination accuracy	100%	100%

Beginning May 19, 2014, HSD and the MCOs began meeting monthly to discuss issues of common concern. Agenda items for the reporting period included:

- Electronic visit verification implementation update.
- Proposal for MCO and children youth with special care needs New Mexico workgroup.
- Meeting with New Mexico Hospital Association on June 5, 2014.
- NFs issues.
- Upcoming LODs.
- Emergency response workgroup and contact information.
- Dental health homes.
- Unreachable members campaign.
- Planning of the care coordination audit.

Other regular meetings related to performance monitoring include:

- Monthly conference calls with each MCO, contract managers, and HSD leadership to discuss continuing transition progress and issues.
- Formal weekly calls with contract managers and their MCOs as well as informal issue-specific contact throughout the week.
- High-utilizer conference calls among MCOs, contract managers, and HSD subject matter experts to oversee and provide guidance to MCO care coordination teams in the management of members who require complex care coordination.

Section XIV: Managed Care Reporting Requirements

MCO Reporting Process

Each MCO is required to submit monthly, quarterly, semi-annual, and annual reports on a regular schedule as defined in the contract. Each MCO is required to submit a total of 96 reports. Ad-hoc reports are requested by HSD as needed. The review process is essential for HSD in its ability to monitor MCO activity and adherence to the contract. For the quarterly update to CMS, HSD will report the most current data that have been reviewed through this process.

In the second quarter, HSD turned its efforts to evaluating the effectiveness of its report review process. A five step evaluation was conducted, recommendations made, and changes implemented to further improve and streamline report review activities (intake, review, and feedback).

In addition to the report reviews, HSD has been establishing baselines for each MCO, conducting comparative analyses to evaluate MCO performance, and checking for anomalies in reporting. From these analyses, HSD determined that MCOs have, on occasion, misinterpreted what was requested for certain data points. These data are being corrected or adjusted, increasing the effectiveness of the reporting process. HSD is continuing to populate data points on its Contract Management Tool which provides a dashboard for each MCO and graphs for comparisons among MCOs.

Behavioral Health Reports

The MCO quarterly BH Utilization Report captures key information about Centennial Care to monitor service utilization patterns. The report was patterned closely after the previous BH utilization reporting template to provide tracking of pre- and post-Centennial Care utilization. The report examines utilization of over 200 BH services in five categories: Inpatient, Residential, Intensive Outpatient, Recovery, and Outpatient. The report shows the unduplicated number of members receiving services by age group, as well as units of service and expenditures. In the first two quarters, the report was exclusively utilization of BH services. In the third quarter, the report has been expanded to include separate reporting on PH and LTC services.

Table 14. Members who Received BH Services in Q1 and Q2

	Unduplicated BH Services Recipients	Total Enrollment Aug 2014	BH service users/All
PHP	20,898	188,277	11.1%
Molina	27,096	197,898	13.7%
UHC	5,545	70,122	7.9%
BCBS	13,089	102,122	12.8%
Total	**66,628**	**558,419**	**11.9%**

Table 15. Members Receiving BH Services in Q2

	Centennial Care Q2	Pre-Centennial Care (Q2 SFY13)
Under 18	25,467	21,948
18-20	2,035	1,480
21-64	26,339	13,155
65 and over	1,155	
Total	**54,996**	**36,424**

New Mexico sought to monitor utilization of BH services to ensure that the capacity for providing services to members was not reduced in Centennial Care. To provide for comparability, Centennial Care utilization in the first six months of the project (Q1 and Q2 CY 2014) is compared to pre-Centennial Care utilization for the first six months of SFY 2013 (Q1 and Q2 SFY 2013). This period of pre-Centennial Care utilization was chosen to reduce any potential impact to the utilization report due to the program integrity activities and pay hold implemented in pre-Centennial Care Q3 and Q4 SFY 2013.

Table 16. Expenditures for BH Services in Q1

PHP	$32,739,754
Molina	$48,521,074
UHC	$8,526,604
BCBS	$24,993,554
Centennial Care Total	**$114,780,986**
Pre-Centennial Care	**$101,954,913**

Table 17. Unduplicated Members Served in Q2

	Centennial Care Q2	Pre-Centennial Care
Inpatient	3,435	1,226
Residential	780	1,116
Intensive Outpatient	830	514
Recovery	7,469	6,839
Outpatient	47,933	34,032
All Services	**54,996**	**36,424**

In the first two quarters, the report shows that the number of members accessing BH services has increased compared to pre-Centennial Care. A significant proportion of members in each MCO received BH services. Members in all age groups are accessing services. A fairly balanced array of service types (e.g., Inpatient versus Outpatient therapy) were provided to members. By the end of the second quarter, overall expenditures for BH services were slightly higher than a similar time-period pre-Centennial Care. In the first two quarters, the average cost of care per member was less than pre-Centennial Care. While 54,966 members received services in the second quarter, 66,628 cumulative members were served in the first six months..

Report #33 is the annual New Mexico Consumer, Family Care Giver and Youth Satisfaction Project (C/F/YSP) survey for members identified with BH needs. The C/F/YSP gives voice to the consumers, family members and youth. The C/F/YSP provides a way to study the alignment of the State's philosophy, federal requirements, and Medicaid and non-Medicaid members' satisfaction with services. The survey is developed through the C/F/YSP State Steering Committee. The committee is a collaborative effort of HSD staff, MCO representatives, the administrator of non-Medicaid BH funds, and consumer and family advocates.

The MCOs gather survey data using an HSD-built and managed web-based data collection tool. Each MCO has a random sample of surveys to be completed. Consumer and family advocate agencies are used to complete the telephone surveys. HSD analyzes the data and will report findings statewide and by MCO in the fall of 2014.

Report #45 is a new report under Centennial Care. The purpose of the report is to capture information on the BH services provided to members through the 16 CSAs in the State. The development of this quarterly report was a collaborative effort between HSD and the MCOs.

The CSAs are multi-service agencies that help to bridge treatment gaps in the child and adult treatment systems, promote the appropriate level of service intensity for members with complex BH service needs, ensure that community support services are integrated into treatment, and develop the capacity for members to have a single point of accountability for identifying and coordinating their BH, PH, and other social services.

For the first year of Centennial Care, quarters one and two were combined and submitted on July 30, 2014. This report will help define CSA membership, services provided that are specific to member needs in regions throughout the State, and member density. Initial results of this report find that the number of Outpatient services provided to individuals with serious mental illness is increasing.

Network Adequacy
Refer to Section II for information related to network adequacy.

Customer Service Reporting
In the first quarter report, HSD provided average percentages which represented overall MCO performance for the metrics detailed below. Corrective actions were implemented for individual MCOs to improve in areas that did not meet the contract standards (see Section IX. Action Plans). With only two exceptions, all metric standards were met by all MCOs as of the May 2014 report.

Call Abandonment Rate
The call abandonment rate contract standard is less than 5%. From February through May 2014, each MCO met this contract standard for all customer service lines (member services, provider services, UM, and nurse advice line). From February through May, BCBS, UHC, and Molina each had an abandonment rate of 4% or lower for each customer service line. PHP had an abandonment rate of 4% or lower, except for the nurse advice line (NAL), which had a 4.2% abandonment rate in February and March. Overall, PHP has had a downward trend for this line

from January at 4.6% to May at 2.3%. All MCOs maintained a less than 2% abandonment rate for the provider services line from February through May 2014.

Calls Answered Within 30 Seconds

The contract standard for calls answered within 30 seconds by a live voice is 85% of total calls received. BCBS did not meet the contract standard for the UM line in January (82%) and in February (83%) but did meet the contract standard for all lines in March through May.

UHC did not meet the contract standard for the UM line in March and in May. All other lines had calls answered within the contract standard. In March, 82% of UM calls were answered within 30 seconds. In April, 85% of UM calls were answered within 30 seconds, the contract standard. In May, the percentage dropped back to 82%. This is being monitored by HSD. Molina met the contract standard from February through May for all lines.

PHP did not meet contract standards for the NAL from January through March; however, by April the contract standard was met at 87%. In May, PHP improved the percentage to 92% of calls answered within 30 seconds.

Average Wait Time for Assistance

The contract standard for average wait time must not exceed two minutes. BCBS, UHC, and Molina have had an average wait time of less than one minute ($\leq$.5) for each customer service line from February through May. The NAL for PHP has had the highest average wait time since February, 0.6 of a minute, which is well within the contract standard.

Voice Mail Returned by Next Business Day

The contract standard specifies that voicemail messages must be returned by the close of business on the next business day for both member and provider customer service lines. BCBS met the contract standard for provider customer service from January through May. BCBS did not meet the contract standard for member customer service as follows: 84% in January, 81% in February and 94% in April. BCBS met the contract standard of 100% in May.

UHC did not meet the contract standard in February (90%) for member customer service, but met the contract standard in March through May. UHC met the contract standard for provider customer service from January through May.

Molina returned 100% of voicemail messages from January through May for member customer service. Molina did not have voicemail messages in February through April from providers and returned 100% of voicemail messages in January and May.

The PHP call center is open 24 hours every day, therefore, voicemail messages were not left by members or providers.

Appeals

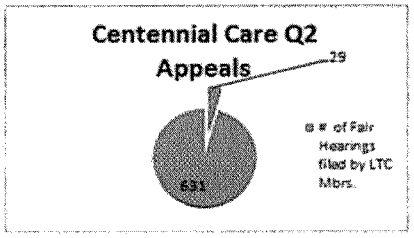
A total of 499 appeals were filed by members of all MCOs in this reporting period. Of the total appeals filed, 292 (59%) of 499 have been upheld, 121 (24%) have been overturned, and 86 (17%) are pending resolution. Appeals have been addressed in a timely manner by the MCOs.

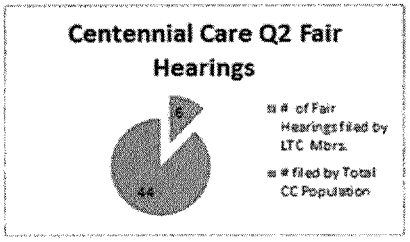
Denial or limited authorization of a requested service has constituted 431 (86%) of the 499 of the total appeals filed. These have included requests for additional BH Inpatient days, requests for DME, requests for additional personal care hours, requests for orthodontics and requests for certain medications. In this reporting period, there has been no evidence of trends by type of appeals filed.

LTC members filed a total of 29 (5%) appeals in the second quarter primarily related to denial or limited authorization of a requested service. These appeals largely constituted requests for additional personal care hours and DME requests. No trends were noted in the type of DME requested. Fair hearings were requested by six LTC members making up 14% of the total fair hearings requested. The fair hearing requests were also for DME and additional personal care hours.

Table 18. LTC Members Appeals and Fair Hearings

Q2 LTC Members Appeals and Fair Hearings	# of Fair Hearings filed by LTC Mbrs.	# filed by Total CC Population	% of total Fair Hearings filed by LTC Members	Primary Type of LTC Appeals
Centennial Care Q2 Appeals	29	631	5%	DME
Centennial Care Q2 Fair Hearings	6	44	14%	PCS hours





Complaints and Grievances
Please refer to Section XII for information regarding complaints and grievances.

Critical Incident Report/Measures to Ensure Participant Protections
Please refer to Section VII for information regarding critical incidents and measures to ensure participant protections.

Section XV: Demonstration Evaluation

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

In the reporting period, HSD conducted activities in search of an independent entity to evaluate Centennial Care using the CMS approved Evaluation Design Plan to ensure that Centennial Care is meeting its goals. The Request for Proposal (RFP) was issued Friday, April 18, 2014 and closed on Thursday, May 29, 2014. The department received two responses to its RFP by the deadline of May 29, 2014. The evaluation committee consisted of five members from various HSD bureaus. The committee met on Thursday, June 12, 2014, to discuss and initially score the proposals.

Based on the initial evaluation, the committee determined evaluation scores and both offerors, were considered to be finalists. Both were asked to submit a best and final offer (BAFO) and participate in the oral presentation phase. The offerors were notified of their selection as finalists by email on Thursday, June 12, 2014. Each of the finalists was given the opportunity to revise their proposals for the purpose of obtaining a best and final offer under the BAFO deadline of Tuesday, June 17, 2014. The BAFOs were submitted, clarified, and amended before the two finalist's oral presentations. The evaluation committee composed a list of topics that were sent to the offerors to address at the oral presentation. The two oral presentations were held on Wednesday, June 18, 2014. Following oral presentations, the evaluation committee met on Wednesday, June 18, 2014 and Thursday, June 19, 2014, to review their scores based on the BAFOs submitted and oral presentations. The committee considered the qualifications, relevant experience, and approach of the two offerors in performing the scope of work specified in the RFPs. Both responders provided informative descriptions of their proposed work plans in meeting the requirements as defined in the RFP.

The Committee has submitted a recommendation that it considers is best to meet the requirements of the work plan as envisioned in the evaluation design of the Centennial Care 1115 demonstration waiver. The timeline is as follows:

Table 19: Centennial Care 1115 Demonstration Waiver Timeline

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

Section XVI: Enclosures/Attachments
Attachment A: Budget Neutrality Table (April 1, 2014—June 30, 2014)
Attachment B: Ad-Hoc Report Examples

Section XVII: State Contacts

Table 20: State Contacts

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

Section XVIII: Additional Comments

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

Centennial Care Member Success Story 1

A care coordinator has been assisting a younger member with completing his community reintegration from a nursing home to his own apartment in the community. Before entering the nursing home, the member had been living in his own apartment, and he was concerned that he wouldn't ever be able to regain his independence. The care coordinator assured him that the community reintegration program was an option for him. He is too young to remain in a nursing home for much longer, much less for the rest of his life. The care coordinator assisted him with moving as soon as possible. The member has several chronic medical problems secondary to obesity. After following a long-term weight loss diet, he has successfully lost 222 pounds to date. He has also completed his physical therapy and was successful in walking up and down the halls of the nursing home, something he hadn't been able to do previously. This helped him to start feeling more independent, and he decided he was ready to move into a home of his own. He even decided he would stay in his home town and didn't feel the need to be in the same city as his family. The member is very talented in computer work and graphic design and getting back to working with those interests in his own apartment has also helped his state of mind.

Centennial Care Member Success Story 2

A care coordinator met with a member while completing a HRA for him in January. She referred him for level 2 care coordination after seeing how many needs he had and how little help he was receiving. The member was reluctantly willing to accept help. Over time he began to be more receptive; he would always say that he was willing to try even though he didn't think any of it would do him any good. The member suffered from substance abuse, depression, and chronic conditions. He had been falling on a regular basis and as a result, frequently ended up in the emergency room. The member had not seen a provider in as long as he could remember and all of his illnesses were going untreated. In addition, he didn't have enough food to eat and could barely get around his home. Over the past several months, the member has now been treated by a PCP. He started antidepressants, thyroid, and high blood pressure medications. His blood pressure and thyroid are both in the normal range now. The member has been going to physical therapy, which he reports is really helping him. He started seeing a BH counselor and he reports this is helping him as well. With the help of care coordination, he is receiving homemaker services, and environmental modifications to his home are being provided. The member now regularly receives Meals on Wheels. The care coordinator has assisted the member with submitting applications for phone, utility, and food assistance, and also with having food commodities delivered from the local food bank on a monthly basis. Most exciting is that the member has stopped drinking. He has been a life-long alcoholic and is successfully recovering. He said it was because others were putting so much effort into his health and well-being; he thought it was the least he could do. The member regularly remarks at how grateful he is and how kind and helpful everyone has been to him. He still has a long road ahead, but it is amazing how just a little bit of caring can make such a deep impact on someone's life.