



## **CENTENNIAL CARE 2.0 DEMONSTRATION**

Section 1115 Annual Report  
Demonstration Year: 6 (1/ 1/ 2019 – 12/ 31/2019)  
Annual Report

April 30, 2020

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# 1

## INTRODUCTION

On December 14, 2018, the Centers for Medicare & Medicaid Services (CMS) approved Centennial Care 2.0, New Mexico's 1115 demonstration waiver, the next iteration of Centennial Care. Centennial Care 2.0, effective January 1, 2019 through December 31, 2023, features an integrated, comprehensive Medicaid delivery system in which a member's Managed Care Organization (MCO) is responsible for coordinating his/her full array of services, including acute care, pharmacy, behavioral health services, institutional services and home and community-based services (HCBS).

In Centennial Care 2.0, the state will continue to advance successful initiatives under Centennial Care while implementing new, targeted initiatives to address specific gaps in care and improve healthcare outcomes for its most vulnerable members. Key initiatives include:

- Improve continuity of coverage, encouraging individuals to obtain health coverage as soon as possible after becoming eligible, increasing utilization of preventive services, and promoting administrative simplification and fiscal sustainability of the Medicaid program;
- Refine care coordination to better meet the needs of high-cost, high-need members, especially during transitions in their setting of care;
- Continue to expand access to long-term services and supports (LTSS) and maintain the progress achieved through rebalancing efforts to serve more members in their homes and communities;
- Improve the integration of behavioral and physical health services, with greater emphasis on other social factors that impact population health;
- Expand payment reform through value-based purchasing (VBP) arrangements to achieve improved quality and better health outcomes;
- Continue the Safety Net Care Pool and time-limited Hospital Quality Improvement Initiative;
- Build upon policies that seek to enhance members' ability to become more active and involved participants in their own health care; and
- Further simplify administrative complexities and implement refinements in program and benefit design.

The Centennial Care 2.0 managed care organizations (MCOs) are:

1. Blue Cross Blue Shield of New Mexico (BCBS),
2. Presbyterian Health Plan (PHP), and
3. Western Sky Community Care (WSCC).

Status of Key Dates:

TOPIC	KEY DATE	STATUS
Substance Use Disorder (SUD) Implementation Plan	Approved by CMS on May 21, 2019	Approved by CMS on May 21, 2019
Evaluation Design Plan	Submitted to CMS on June 27, 2019	Pending CMS approval
Quality Strategy	Submitted to CMS on March 14, 2019	Pending CMS review and feedback

# 2

## ENROLLMENT AND BENEFITS INFORMATION

### QUARTER 4 MCO ENROLLMENT CHANGES

MANAGED CARE ORGANIZATION	9/30/2019 ENROLLMENT	12/31/2019 ENROLLMENT	PERCENT INCREASE/ DECREASE Q3
Blue Cross Blue Shield of New Mexico (BCBS)	234,169	236,328	+9%
Presbyterian Health Plan (PHP)	371, 288	373,205	+5%
Western Sky Community Care (WSCC)	59,048	61,164	+3.5%

Source: Medicaid Eligibility Reports, September 2019 & December 2019

### CENTENNIAL CARE 2.0 MANAGED CARE ENROLLMENT

Centennial Care 2.0 MCO enrollment data and cost per unit data by programs is provided for October 1, 2017 to September 30, 2019. Please see Attachment A: October 2017 through September 2019 - Statewide Dashboards.

#### ***MCO Enrollment***

In aggregate, MCO enrollment is decreasing by 1% from the previous period. Approximately half of this decrease is attributable to program-wide member redetermination review. This decrease is comprised of the following:

- 2% decrease in physical health enrollment;
- 1% decrease in aggregate Long-term services and supports enrollment. The 6% decrease to NF LOC Medicaid Only members is partially offset by the 10% increase in Self Directed enrollment; and
- 1% increase in other adult group enrollment.

## ***MCO Per Capita Medical Costs***

- In aggregate, MCO per capita medical costs is increasing by 4% from the previous to current period, this consists of a 2% decrease to pharmacy services and 5% increase to non-pharmacy services.
  - The decrease in pharmacy costs from the prior period to the current period is driven by the decreasing cost in Hepatitis C therapies.
- The following fee and benefit changes have been implemented in the current period and are not reflected in previous period. These changes include fee increase as well as the addition of new benefits and contribute to the overall increase in program per capita costs:
  - Effective 7/1/2018 (included in 1 quarter of year 1, included in all of year 2)
    - Physician Office Visit Reimbursement fee increase - increase to the FFS reimbursement for physician office visits for procedure code 99213 from 71.2% of the Medicare fee schedule to 75.0% of the Medicare fee schedule.
    - Nursing Facility Fee increase - increase to the FFS reimbursement for nursing facilities by 7.84%.
    - Assisted Living Reimbursement fee increase - increase to the FFS reimbursement for assisted living (procedure codes T2030 and T2031) by 1.0%.
    - Adult Day Health Reimbursement fee increase - increasing its FFS reimbursement for adult day health (procedure code S5100) by 38.7%.
    - Phase 1 Behavioral Health Benefit and Fee Changes - increase to the FFS reimbursement for TFC, ACT, group therapy, CCSS (performed in the community setting), and therapy services performed after hours by 20%.
  - Effective 1/1/2019 (not included in year 1, included in 3 quarters of year 2)
    - Long-Acting Reversible Contraceptive Fee Increase - increase to the FFS reimbursement for procedure codes 11981 and 11983 by 25% and procedure code 58300 by 200%.
    - Community Benefit Fee increase – increase to the FFS reimbursement for community benefit services by 1%. The CC-OAG Alternative Benefit Plan (ABP) exempt population is eligible to receive the community benefit.
    - Child Accredited Residential Treatment Center Payment Change - changes to the FFS fee schedule for revenue codes 1001 to increase the daily rate for child accredited residential treatment centers (ARTCs) from \$270 to \$350 per day
    - New benefit for Home visiting pilot programs Nurse Family Partners (NFP) and Parents as Teachers (PAT).

- Transition from supplemental grant funding to Managed Care coverage for Brief Intervention, and Referral to Treatment Services.
- Phase 2 Behavioral Health Benefit and Fee Changes- expanded billing procedures to allow for increased reimbursement of recovery services provided in a family peer support environment, complex and non-complex interdisciplinary teaming assessments, partial hospitalization services, in addition to expanding Opioid Treatment Plans (OTP) to existing clinics, allowing Behavioral Health Associates (BHA) to bill Comprehensive Community Support Services (CCSS), and adding additional Intensive Outpatient Programs (IOP).
- Effective 7/1/2019 (not included in year 1, included in 1 quarter of year 2)
  - E&M Fee Schedule Increase – increase to all FFS rates for procedure codes 99201-99499 below 90% to 90% of the CY2019 Medicare fee schedules. FFS procedure codes already above 90% remain unchanged. Procedure codes without a corresponding Medicare fee schedule have been increased by 14.5%.
  - Assisted Living Fee Increase – 5% increase to procedure codes T2030 and T2031
  - Community Pharmacy Dispensing Fee increase - \$2 increase to dispensing fees for select pharmacies
  - Chronic Care Management/Transitional Care Management – implementation of new services for non-dual Medicaid populations
  - Hospital Fee Increase – increase of 5% to inpatient services and 10% increase to outpatient services for State Teaching Hospitals; 14% increase to inpatient services and 25% increase to outpatient services for SNCP providers; 12% increase to inpatient services and 18% increase to outpatient services for all remaining in-state hospitals.
  - Pre-Tenancy – implementation of new services for members with SMI.
  - Personal Care Services Fee Increase - \$.50 per hour increase to procedure codes T1019 and 99505
  - Dental Fee Schedule Increase – increase of 2% to dental reimbursement rates
  - Dental Fluoride with Varnish – implementation of new services and procedure codes D1026 and 99188.

## **CENTENNIAL CARE 1.0 TO CENTENNIAL CARE 2.0 TRANSITION**

### ***Molina Healthcare Plan Termination***

In DY6 Q4, MHC continued to provide monthly updates on the progress of its termination plan. Based on HSD's review, MHC has submitted all required program reports for 2018 and is current with all termination plan deliverables. MHC is required to comply with all duties and obligations incurred prior to the contract termination date and to maintain functionality to complete processing of all claims. HSD will continue to work with MHC and monitor the termination plan.

### ***UnitedHealthcare Community Plan Termination***

In DY6 Q4, UHC continued to submit monthly termination plan updates. HSD monitored progress and worked with UHC to identify any outstanding reports, and financial responsibilities. UHC provided rebuttal comments to several draft reviews by the EQRO. At the end of Q4, HSD provided final reconciliations to UHC. All HSD payments and recoupments have been completed.

## **CENTENNIAL REWARDS**

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

- Adult PCP Checkup – reward for adults who complete an annual PCP wellness checkup;
- Asthma Management – reward for refills of asthma controller medications for children;
- Bipolar – reward for members who refill their medications;
- Bone Density – reward for women age 65 or older who complete a bone density test within the year;
- Dental – reward for adults and children who complete annual dental visits;
- Diabetes – reward for members who complete tests and exams to better manage their diabetes;
- Pregnancy – reward for prenatal first trimester and postpartum visit; and
- Schizophrenia – reward for medication refill.
- Step-Up Challenge – reward for completing a walking challenge;
- Well-Child for ages Birth – 15 Month (aka W15)

Participating Members who complete these activities can earn credits, which can then be redeemed for items in the Centennial Rewards catalog.



**Table 1: Centennial Care Rewards**

<b>CENTENNIAL CARE REWARDS (JANUARY- DECEMBER 2019)</b>				
	<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>
Number of Medicaid Enrollees Receiving a Centennial Care Rewardable Service this Quarter*	74,110	200,475	116,496	87,555
Number of Members Registered in the Rewards Program this Quarter.	4,215	5,497	5,339	82,019
Number of members Who Redeemed Rewards this Quarter**	7,797	18,263	20,238	41,782

\*Only includes rewards earned THIS quarter.

\*\*Redeemed rewards could have been earned in any of the previous 24 reporting months.

### **2019 Centennial Care Rewards Program Highlights**

- In 2019, over 23,000 new registered accounts were created for the Centennial Rewards program, continuing the year-over-year growth trend.
- Two additional rewards – Adult PCP Visit and Well Child Visits for Infants – were added to the Centennial Rewards program in 2019. These programs garnered some of the highest levels of earning for members in 2019. Specifically, members earned \$2.3 million more than in 2018.
- In 2019, over 375,000 unique members earned at least one reward, which results in a 42% cumulative participation rate in SFY 2019.

# 3

## ENROLLMENT COUNTS FOR QUARTER AND YEAR TO DATE

The following table outlines all enrollment and disenrollment activity under the demonstration. The enrollment counts are unique enrollee counts, not member months. Please note that these numbers reflect current enrollment and disenrollment 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. Also, a majority of disenrollment for this quarter is attributed to members losing eligibility, moving out of state, or becoming incarcerated.

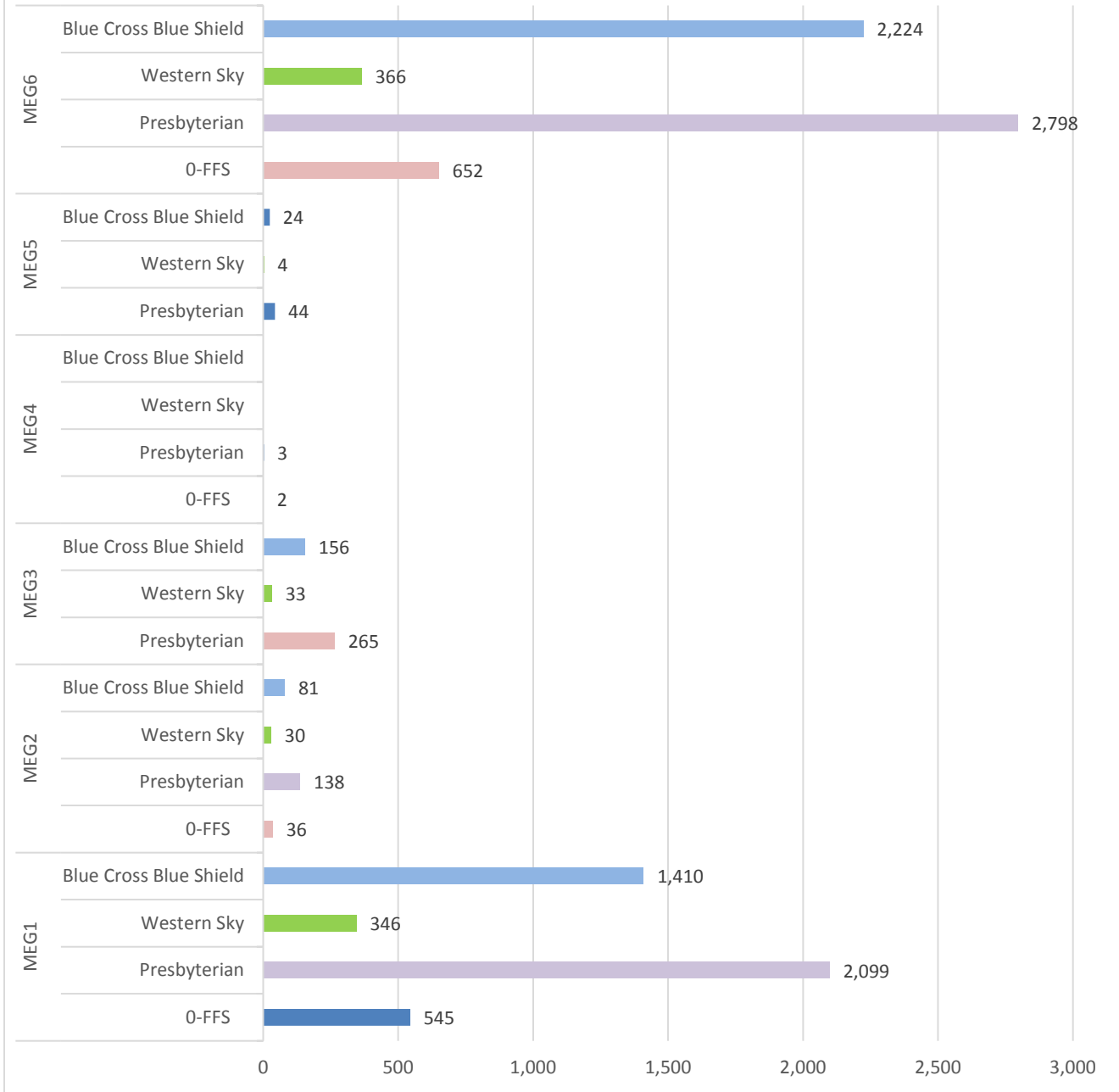
Demonstration Population		Total Number Demonstration Participants DY6 Q4 Ending December 2019	Current Enrollees (Rolling 12-month Period)	Total Disenrollment During DY6 Q4
Population MEG1 - TANF and Related	0-FFS	37,572	53,819	545
	Presbyterian	179,875	224,782	2,099
	Western Sky	30,655	40,308	346
	Blue Cross Blue Shield	108,993	127,842	1,410
	<b>Summary</b>	<b>357,095</b>	<b>446,751</b>	<b>4,400</b>
Population MEG2 - SSI and Related - Medicaid Only	0-FFS	2,479	3,430	36
	Presbyterian	20,258	22,171	138
	Western Sky	3,480	3,893	30
	Blue Cross Blue Shield	11,351	11,540	81
	<b>Summary</b>	<b>37,568</b>	<b>41,034</b>	<b>285</b>
Population MEG3 - SSI and Related - Dual	0-FFS		117	
	Presbyterian	23,086	24,719	265
	Western Sky	2,403	2,609	33
	Blue Cross Blue Shield	10,656	10,934	156
	<b>Summary</b>	<b>36,145</b>	<b>38,379</b>	<b>454</b>
Population MEG4 - 217-like Group - Medicaid Only	0-FFS	112	209	2
	Presbyterian	125	147	3
	Western Sky	16	15	
	Blue Cross Blue Shield	98	115	
	<b>Summary</b>	<b>351</b>	<b>486</b>	<b>5</b>

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Population MEG5 - 217-like Group - Dual	0-FFS		9	
	Presbyterian	2,420	2,543	44
	Western Sky	261	253	4
	Blue Cross Blue Shield	1,770	1,691	24
	Summary	4,451	4,496	72
Population MEG6 - VIII Group (expansion)	0-FFS	29,908	34,300	652
	Presbyterian	130,663	131,770	2,798
	Western Sky	21,724	22,825	366
	Blue Cross Blue Shield	94,787	92,276	2,224
	Summary	277,082	281,171	6,040
Summary		712,692	812,317	11,256

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### Total Disenrollments During DY6 Q4



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# 4

## OUTREACH/ INNOVATIVE ACTIVITIES TO ASSURE ACCESS

OUTREACH AND TRAINING	
DY6 Activities	<p>In DY6 Q4, HSD outreach and training staff partnered with the New Mexico Health Insurance Exchange in a state-wide Enrollment Event for potential Medicaid applicants using the Real Time Application system process at over 26 locations.</p> <p>In DY6, HSD staff conducted monthly trainings for the Presumptive Eligibility (PE) Program and Presumptive Eligibility Determiners (PED) in the JUST Health Program. HSD also conducted YESNM-PE Demonstration trainings for PEDs. The purpose for these on-going trainings is to increase PED enrollment throughout New Mexico. Trainings take place in person, classroom environment and also via webinar.</p> <p>HSD outreach staff presented information regarding Centennial Care 2.0 Medicaid Benefits, Eligibility and MCO Enrollment at the following state-wide events:</p> <ul style="list-style-type: none"><li>• Annual Conference on Aging</li><li>• Zuni Pueblo Health Benefits &amp; Outreach/Education Fair</li><li>• Senior Day at the New Mexico State Fair</li><li>• New Mexico Primary Care Association Outreach &amp; Enrollment Conference</li></ul>

# 5

## COLLECTION AND VERIFICATION OF ENCOUNTER DATA AND ENROLLMENT DATA

The MCOs submit encounters daily and/or weekly to stay current with encounter submissions, including encounters that are or not accepted by HSD. HSD meets regularly with the MCOs to address specific issues and to provide guidance. HSD regularly monitors encounters by comparing encounter submissions to financial reports to ensure completeness. HSD monitors encounters by extracting data monthly to identify the timeliness and accuracy of encounter submissions and shares this information with MCO's. HSD extracts encounter data on a quarterly basis to validate and enforce compliance with accuracy. Based on the most recent quarterly data extracted, the MCO's are compliant with encounter submissions.

Data is extracted monthly to identify Centennial Care enrollment by MCO and for various populations. Any discrepancies that are identified, whether due to systematic or manual error, are immediately addressed. Eligibility and enrollment reports are run on a monthly basis to ensure consistency of numbers. In addition, HSD continues to monitor enrollment and any anomalies that may arise, so they are identified and addressed timely. HSD posts the monthly Medicaid Eligibility Reports (MERs) to the HSD website at: <http://www.hsd.state.nm.us/LookingForInformation/medicad-eligibility.aspx>. This report includes enrollment by MCOs and by population.

# 6

## OPERATIONAL/POLICY/SYSTEMS/FISCAL DEVELOPMENT/ISSUES

### FISCAL ISSUES

The capitation payments through Quarter 4 of demonstration year (DY) 6 reflect the Centennial Care 2.0 rates effective on January 1, 2019, the rate updates that were effective on April 1, 2019 to account for full contracting with the teaching hospital, and the mid-year rate update. The July 1, 2019 rate update approved on August 28, 2019 include the following programmatic and rate changes:

- Professional fee schedule increase
- Assisted living fee schedule increase
- Community based pharmacy increased dispensing fee
- Benefit changes for transitional care management and chronic care management
- Increases to hospital reimbursement
- Increased reimbursement for personal care services
- Increase to professional dental reimbursement
- Benefit changes for dental fluoride with varnish
- Peer delivered pre-tenancy and tenancy services

The rate update effective on October 1, 2019 accounts for the following additional provider rate changes:

- Federally qualified health centers (FQHC) encounter rate increases
- Behavioral health outpatient fee schedule increase
- Not-for-profit community hospitals rate increase
- Extension for community health care outcomes (Project ECHO)
- Regional nursing facility increase
- NMHIX assessment

The additional changes listed above further increase the cost and PMPM for all MEGs, except MEG 5, for DY 6.

During DY6 Q4, reconciliation payments and recoupments for patient liability, retroactive eligibility, IHS, hepatitis C, and underwriting gain limit were made for CY 2017 (DY 4); the effects of those activities are more pronounced in the PMPM of MEGs 1 and 2. For CY 2018 (DY 5), payments were made for patient liability, retroactive eligibility and IHS reconciliations along with a recoupment for performance measure penalty resulting in an increase in the PMPM of all MEGs, except MEG 6.

## **PATIENT CENTERED MEDICAL HOMES (PCMH)**

HSD requires the MCOs to ensure engagement of PCMHs by including PCMH membership as part of a delivery system improvement project.

- For Legacy MCOs, HSD requires a minimum of a five percent (5%) increase of the MCO's members assigned to a PCP who is a provider with a Patient-Centered Medical Home (including both PCMHs that have achieved NCQA accreditation and those that have not). If the MCO achieves a minimum of fifty percent (50%) of membership being served by PCMHs, then the MCO must maintain that same minimum percentage at the end of the calendar year in order to meet this target.
- For non-Legacy MCOs, HSD requires a minimum of ten percent (10%) of the MCO's total membership be assigned to a PCP who is a provider with a Patient-Centered Medical Home (including both PCMHs that have achieved NCQA accreditation and those that have not) by the end of the calendar year.

HSD may impose a penalty if the MCO does not meet the Delivery System Improvement performance targets, however, the MCO may propose that any performance penalty amounts be spent on system improvement activities for provider network development and enhancement activities that will directly benefit members.



**Table 2: PCMH Assignment**

<b>PCMH ASSIGNMENT</b>				
<b>Total Members Panelled to a PCMH</b>				
	<b>DY6 Q1</b>	<b>DY6 Q2</b>	<b>DY6 Q3</b>	<b>DY6 Q4</b>
BCBS	95,670	100,387	106,497	107,831
PHP	196,853	203,851	213,475	239,583
WSCC	20,164	21,682	22,705	23,460
<b>Percent of Members Panelled to a PCMH</b>				
BCBS	39.8%	41.4%	43.3%	44.0%
PHP	53.0%	55.0%	57.5%	64.7%
WSCC	34.4%	37.1%	38.2%	39.3%

## Care Coordination Monitoring Activities

### DY6 Activities

In DY6, HSD instituted monthly audits to monitor MCO compliance with contract and policy requirements when conducting care coordination activities. These audits include: 1) MCO compliance for the correct categorization of members who have been listed as Difficult to Engage, Unreachable or Refused care coordination (DUR); 2) Confirmation that members are correctly being referred for a Comprehensive Needs Assessment (CNA) if triggered by a completed Health Risk Assessment (HRA); 3) Correct placement of members in Care Coordination Level (CCL) based on information in the CNA and criteria outlined in the Managed Care Service Agreement; and 4) Transition of Care (TOC) files for members transitioning from an in-patient hospital stay or Nursing Facility to the community, confirming the TOC plan met all contract requirements and adequately addressed the member's needs.

DY6 audit results from the Monthly DUR Audit are aggregated quarterly in Table 3: Care Coordination Categorization Audit. HSD provided audit findings, each month, to the MCOs with requests for further information, additional outreach attempts, recategorization of members to the correct care coordination level when warranted, and targeted training for staff. HSD conducted monthly care coordination calls with each MCO in DY6 to follow up with their audit finding responses, answer questions, or provide technical assistance as needed. Based on the audit findings and the monthly calls, the MCOs have conducted additional outreach, re-assessed members and provided targeted training to care coordination staff. These efforts have improved contract compliance.

**Table 3: Care Coordination Categorization Audit**

<b>DUR AUDIT</b>	<b>DY6 Q1</b>	<b>DY6 Q2</b>	<b>DY6 Q3</b>	<b>DY6 Q4</b>
<b>Difficult to Engage (DTE)</b>				
<b>Number of member files audited</b>	<b>83</b>	<b>90</b>	<b>89</b>	<b>90</b>
BCBS	30	30	29	30
PHP	30	30	30	30
WSCC	23	30	30	30
<b>Number of member files correctly categorized</b>	<b>52</b>	<b>65</b>	<b>78</b>	<b>74</b>
BCBS	27	17	26	18
PHP	15	21	26	27
WSCC	10	27	26	29
<b>% of member files correctly categorized</b>	<b>63%</b>	<b>72%</b>	<b>88%</b>	<b>82%</b>
BCBS	90%	57%	90%	60%
PHP	50%	70%	87%	90%
WSCC	43%	90%	87%	97%
<b>Unable to Reach (UTR)</b>				
<b>Number of member files audited</b>	<b>90</b>	<b>90</b>	<b>89</b>	<b>90</b>
BCBS	30	30	29	30
PHP	30	30	30	30
WSCC	30	30	30	30
<b>Number of member files correctly categorized</b>	<b>61</b>	<b>54</b>	<b>65</b>	<b>87</b>
BCBS	22	18	16	29
PHP	19	13	23	29
WSCC	20	23	26	29
<b>% of member files correctly categorized</b>	<b>68%</b>	<b>60%</b>	<b>73%</b>	<b>97%</b>
BCBS	73%	60%	55%	97%
PHP	63%	43%	77%	97%
WSCC	67%	77%	87%	97%
<b>Refused Care Coordination (RCC)</b>				
<b>Number of member files audited</b>	<b>90</b>	<b>90</b>	<b>90</b>	<b>90</b>
BCBS	30	30	30	30
PHP	30	30	30	30
WSCC	30	30	30	30
<b>Number of member files correctly categorized</b>	<b>73</b>	<b>82</b>	<b>83</b>	<b>68</b>
BCBS	25	27	29	26
PHP	26	29	25	27
WSCC	22	26	29	15

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<b>% of member files correctly categorized</b>	<b>81%</b>	<b>91%</b>	<b>92%</b>	<b>76%</b>
BCBS	83%	90%	97%	87%
PHP	87%	97%	83%	90%
WSCC	73%	87%	97%	50%

HSD conducted two trainings in DY6 with the MCOs focusing on results from monthly audits and quarterly compliance reports. A specific focus of the trainings was HSD contract and policy requirements for members transitioning from an inpatient setting or a nursing facility back to the community. HSD also focused on Transition of Care (TOC) requirements during monthly MCO calls and monthly audit findings. These efforts have improved contract compliance.

DY6 results for the Transition of Care Audit are listed in Table 4. During monthly calls, HSD discussed contract requirements for TOC plans, follow-up care, and follow-up assessments with each MCO. HSD requested updates on specific members whose audited file did not comply with contract requirements. HSD received updates on all requested members with specific steps taken to complete required TOC elements.

**Table 4: Transition of Care Audit**

<b>TOC AUDIT</b>	<b>DY6 Q1</b>	<b>DY6 Q2</b>	<b>DY6 Q3</b>	<b>DY6 Q4</b>
<b>Inpatient (IP)</b>				
<b>Number of member files audited</b>	<b>74</b>	<b>44</b>	<b>48</b>	<b>78</b>
BCBSNM	30	15	15	30
PHP	28	14	15	30
WSCC	16	15	18	18
<b>Number of member files meeting HSD contract requirements</b>	<b>29</b>	<b>25</b>	<b>39</b>	<b>59</b>
BCBSNM	14	8	12	25
PHP	10	9	12	25
WSCC	5	8	15	9
<b>% of member files meeting HSD contract requirements</b>	<b>39%</b>	<b>57%</b>	<b>81%</b>	<b>76%</b>
BCBSNM	47%	53%	80%	83%
PHP	36%	64%	80%	83%
WSCC	31%	53%	83%	50%
<b>Nursing Facility (NF)</b>				
<b>Number of member files audited</b>	<b>42</b>	<b>32</b>	<b>28</b>	<b>47</b>
BCBSNM	23	15	12	25
PHP	19	15	15	19
WSCC	0	2	1	3
<b>Number of member files meeting HSD contract</b>	<b>19</b>	<b>21</b>	<b>23</b>	<b>41</b>

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TOC AUDIT	DY6 Q1	DY6 Q2	DY6 Q3	DY6 Q4
<b>requirements</b>				
BCBSNM	15	10	11	21
PHP	4	9	11	17
WSCC	n/a	2	1	3
<b>% of member files meeting HSD contract requirements</b>	<b>45%</b>	<b>55%</b>	<b>82%</b>	<b>87%</b>
BCBSNM	65%	67%	92%	84%
PHP	21%	60%	73%	89%
WSCC	n/a	100%	100%	100%

HSD conducted monthly Health Risk Assessment (HRA) and Care Coordination Level (CCL) Audits in DY6.

DY6 audit results for the HRA and CCL are in Table 5: Health Risk Assessment and Care Coordination Level Audit. HSD conducted audits of HRAs to ensure that members were appropriately referred for a CNA. HSD requested follow-up be conducted with members requiring a CNA. Each MCO provided clarification for any discrepancies identified in the HRA audit. In the CCL audit, HSD conducted reviews of CNAs to ensure that members were given the correct Care Coordination Level. If discrepancies were identified, HSD requested the MCO reassess identified members to determine the correct Care Coordination Level per contract and policy.

**Table 5: Health Risk Assessment and Care Coordination Level Audit**

HRA AUDIT	DY6 Q1	DY6 Q2	DY6 Q3	DY6 Q4
<b>Number of member files audited</b>	<b>90</b>	<b>75</b>	<b>90</b>	<b>90</b>
BCBSNM	30	25	30	30
PHP	30	25	30	30
WSCC	30	25	30	30
<b>Number of member files correctly referred for a CNA</b>	<b>87</b>	<b>75</b>	<b>89</b>	<b>90</b>
BCBSNM	29	25	30	30
PHP	30	25	29	30
WSCC	28	25	30	30
<b>% of member files correctly referred for a CNA</b>	<b>97%</b>	<b>100%</b>	<b>99%</b>	<b>100%</b>
BCBSNM	97%	100%	100%	100%
PHP	100%	100%	97%	100%
WSCC	93%	100%	100%	100%
CCL AUDIT				
<b>Number of member files audited</b>	<b>90</b>	<b>75</b>	<b>90</b>	<b>90</b>
BCBSNM	30	25	30	30
PHP	30	25	30	30
WSCC	30	25	30	30

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HRA AUDIT	DY6 Q1	DY6 Q2	DY6 Q3	DY6 Q4
<b>Number of member files with correctly assigned CCL</b>	<b>86</b>	<b>73</b>	<b>85</b>	<b>70</b>
BCBSNM	28	24	29	24
PHP	29	24	29	23
WSCC	29	25	27	23
<b>% of member files with correctly assigned CCL</b>	<b>96%</b>	<b>97%</b>	<b>94%</b>	<b>78%</b>
BCBSNM	93%	96%	97%	80%
PHP	97%	96%	97%	77%
WSCC	97%	100%	90%	77%

In DY6, HSD continued to conduct care coordination “ride-alongs” with MCO care coordinators to observe member CNA and other assessments in the home setting. HSD staff conducted ride-alongs with all MCOs observing initial and follow-up CNAs. HSD placed emphasis on care coordinators administering the Community Benefit Services Questionnaire (CBSQ) and the Community Benefit Member Agreement (CBMA) to ensure the member agrees to accept or decline community benefits.

HSD provided feedback to the MCOs regarding an assessment of the strengths, and opportunities for improvement, of the care coordinator performance completing the assessment, communicating about benefits, services, and engaging with the member. HSD will continue to monitor the MCOs’ Care Coordination activities identify and address any trends and provide technical assistance as needed.

## BEHAVIORAL HEALTH

In DY6 the Managed Care Organizations (MCOs), in collaboration with the State, continued to review the access and availability of behavioral health services. Collaboration between MCOs, the New Mexico Behavioral Health Provider Association (NMBHPA) and the State, through workgroups, seeks to determine additional ways to increase the access to behavioral health services statewide. Ongoing efforts include individual MCOs meeting with individual provider agencies to encourage additional providers to engage in the Treat First model or Open Access models. This has resulted in many large providers in the state adopting Treat First and/or Open Access models that support the availability of timely appointment access for members. Additionally, providers have increased group therapy sessions and group recovery support services to allow greater access to services. More Comprehensive Community Support Services (CCSS) and Intensive Outpatient Program (IOP) approvals were issued by the State during DY6 to increase service availability.

MCOs are continuing to look at value-based purchasing agreements with large providers to increase access and appointment availability and are working to increase High Fidelity Wrap-around services for children through initiatives with Health Homes. MCOs' network contracting teams have continually monitored the out-of-network providers from their single case agreement files to recruit additional practitioners to participate in the behavioral health network as border area providers.

## **SUD IMPLEMENTATION**

The New Mexico Human Services Department has initiated new improvements to the Centennial Care 2.0 program with up to \$34 million in enhancements, intended to fill behavioral health service gaps and expand services to include:

- Individual and Family Peer Support
- After hours, weekends and holiday service
- Assertive Community Treatment
- Comprehensive Community Support Services
- Crisis Treatment Center and Crisis Stabilization
- Intensive Outpatient Services
- Opioid Treatment Program
- Partial Hospitalization expansion/incentives
- Screening, Brief Intervention and Referral to Treatment
- Accredited Residential Treatment Centers

The State has worked in DY6 to build Crisis Treatment Center/Crisis Stabilization sites, along with Adult Accredited Residential Treatment Centers services, helping to establish their accreditation and Medicaid rate setting. Several providers have now been trained in Screening, Brief Intervention and Referral to Treatment (SBIRT) along with increasing the number of approved Intensive Outpatient Services (IOP) and Comprehensive Community Support Services (CCSS) providers.

## **SUD HEALTH IT**

100% of prescribers are utilizing the Pharmacy Prescription Monitoring Program (PMP). It has been updated to a new platform called PMPAWARxE which allows end users, prescribers and dispensers to make better informed decisions and intervene earlier through advanced analytics. PMPAWARxE can quickly identify, anticipate, and manage improper prescribing and dispensing of controlled substances. Letters are being sent to providers when over-prescribing is discovered, and training regarding best practices is available through interactive telecommunications (ECHO). The rule regulating the PMP recently underwent a major rewrite addressing issues such as the change to mandatory reporting by dispensers to within 1 business day of a prescription being filled. The PMP has been integrated with the Emergency Department Information Exchange (EDIE) which most hospitals are using, and progress is being made on integration with varying electronic health records (EHRs).

## **BH INTEGRATION**

### ***Promoting Integration of Primary and Behavioral Health Care Grant (PIPBHC)***

During its first year, PIPBHC met its enrollment numbers of 120 individuals, exceeded the required reassessment rate (80%) by 14%, met its required training and policy/process change reporting requirements, and submitted its annual report and a sustainability plan to SAMHSA on time. Trainings this year included a two-day Life Link practical action peer training and a two-day Whole Health Action Management (WHAM) training for grant Certified Peer Support Workers and Community Health Workers as well as others from around the state. Guidance Center of Lea County (GCLC) presented the Sanctuary Model of trauma-informed care for leadership at Hidalgo Medical Services (HMS). Other successes include the development of a custom integration measurement tool as well as a protocol to chart integration progress in both agencies, and the creation of an Advisory Council. The council meets quarterly to ensure local lessons at agencies inform state stakeholders about challenges/successes re: primary care/behavioral health (PC/BH) integration.

In addition, Guidance Center of Lea County has expanded the number of referring primary care providers in the community and improved two-way communication processes regarding mutual PIPBHC clients. The Guidance Center now locates a behavioral health provider at a pain clinic in Hobbs half day/week, and is working on a MOA with Lovington Nor Lea Hospital for referrals and health and wellness promotion activities. HMS plans to launch an integration pilot with a lead primary care physician who is building a geriatric practice at the agency to identify and address agency-wide communication and coordination challenges. HMS is seeing more agency primary care and dental providers reaching out to PIPBHC staff regarding enrolled clients, and is planning to establish a regularly scheduled, agency-wide integration meeting.

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## Health Homes

On April 1, 2016, HSD launched the first two health homes, CareLink NM (CLNM), to provide integrated care coordination services to Medicaid-eligible adults with serious mental illness (SMI) and children and adolescents with severe emotional disturbance (SED). On April 1, 2018, HSD implemented Health Homes services in eight additional counties to address the same target population. Seven providers now offer health homes in 12 counties. Two health homes (Guidance Center Lea County and Mental Health Resources, Roosevelt County) provide high fidelity wraparound services. During calendar year 2019, these two programs served 129 families and their children with SED and complex behavioral health challenges. Wraparound clients are involved with multiple state systems, and many have been in out-of-state residential treatment centers.

### CLNM Health Home Activities

#### DY6 Activities

HSD conducted site visits with all health home providers to identify barriers to enrollment and develop strategies to address challenges, improve marketing, and increase networking opportunities appropriate to each community. Additional site visits were conducted with health home providers to monitor service delivery, program fidelity, and data collection and reporting. Site visits also included the delivery of technical assistance and program support.

HSD oversaw updates to the BHSD Star data collection tool to better align client support services with the six mandated health home core services.

HSD drafted a state plan amendment to add substance use disorder to the eligibility criteria for health homes. To support this effort, the health home policy manual is being updated and the state rule is being amended.

The CLNM Steering Committee met regularly to review policies and procedures for timely delivery of CLNM services, completion of comprehensive needs assessments, and MCO referral activities. The steering committee updated qualifications for staff and program

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	requirements for health homes to deliver services to clients with SUD diagnoses.
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**Table 6: Number of Members Enrolled in CareLink Health Homes**

<b>CareLink New Mexico Health Home Enrollment CY 2019</b>			
<b>Q1 (January – March 2019)</b>	<b>Q2 (April – June 2019)</b>	<b>Q3 (July – September 2019)</b>	<b>Q4 (October – December 2019)</b>
2,540	2,814	3,228	3,637

## ***Supportive Housing***

The supportive housing benefit in Centennial Care 2.0, approved by the Center for Medicaid Services (CMS), supports Medicaid eligible individuals enrolled in the Linkages Permanent Supportive Housing program with pre-tenancy and tenancy services. Certified Peer Support Workers of the Linkages Support Service providers will provide the pre-tenancy and tenancy service; certification of peers is through the Behavioral Health Services Division. Linkages serves individuals with serious mental illness with functional impairment who are homeless or precariously housed and extremely low-income level, per the Department of Housing and Urban Development (HUD) guidelines.

On August 14, 2019, the Supportive Housing Program Manager from the Human Services Department provided training with MCOs on the following training:

- Supportive Housing Program – client verification (no MCO prior authorization needed)
- Provide information about range of billable supports and requirement for the bundled rate
- Billing codes/fee schedule and Billing and Policy Manual

The BHSD Supportive Housing Program Manager continues to provide technical assistance to Linkages Support Service providers and MCOs, as requested and as necessary. The Supportive Housing Program Manager scheduled a conference call with all Linkages Support Service providers to follow up about Medicaid codes.

## **COMMUNITY HEALTH WORKERS (CHWs)**

CY19 was a baseline year for the Centennial Care 2.0 MCOs to provide 3 percent of total member enrollment with Community Health Workers (CHWs) and Community Health Representatives (CHRs) services, as part of the CHW Delivery System Improvement Performance Target (DSIPT). The MCOs reported a total of 163 CHWs employed or contracted in CY19.

Workforce titles include, CHWs, CHRs, Community Paramedics, Family Support Specialists and Peer Support Workers (PSWs). CHRs are reported to serve members in the Navajo Nation area of the state with services that include native language translation.

HSD has discontinued this DS IPT for CY20, thus the CY19 reporting will be the final for CHWs.

**Table 7: Community Health Worker Workforce**

COMMUNITY HEALTH WORKER WORKFORCE ( JANUARY – DECEMBER 2019 )	
M CO	T O T A L
BCBS	61
PHP	49
WSCC	53
Total	163

CHW interventions provided in DY6 Q4 included the following types of services:

- Social Determinates of Health Assessment
- Health Assistance-including PCP appointments, HRAs, and preventative care
- Health Education
- Hepatitis C Treatment Outreach
- Smoking Cessation
- Recovery Support Assistance
- ED Education Post-Discharge Follow-ups
- Prenatal & Postpartum Care Program
- Translation Services

Unduplicated members served in rural, frontier and urban areas by MCO reached 28,559 for CY19.

**Table 8: Unduplicated Members Served by CHWs**

UNDUPLICATED MEMBERS SERVED BY CHWS ( JANUARY – DECEMBER 2019 )	
M CO	T O T A L
BCBS	15,048
PHP	11,647
WSCC	1,864
Total	28,559

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MCO reporting includes geographic utilization of CHW services by county of member residence in urban, rural and frontier regions of New Mexico.

**Table 9: Geographic Utilization of CHWs**

GEOGRAPHIC UTILIZATION OF CHWS (JANUARY – DECEMBER 2019)			
M CO	URBAN	RURAL	FRONTIER
BCBS	9,184	4,874	990
PHP	7,184	3,601	862
WSCC	1,046	731	87
Total	17,414	9,206	1,939

**Centennial Home Visiting (CHV) Pilot Program**

In DY6, the numbers of CC MCO pregnant member enrollments for each home visiting (HV) program are as follows:

- Nurse Family Partnership (NFP):** 44 members

There were two newly hired NFP nursing staff at the UNM Center for Development and Disability (UNM CDD) dedicated for the CHV Pilot Program in Bernalillo County. Per the NFP model, the UNM CDD NFP program had a capacity of 25 new families for which each one of the new nurses can be responsible. In the latter half of DY6, UNM CDD NFP Program’s capacity was 50 and the program received adequate referrals to be able to fill up the vacant spots. However, in December 2019, the enrollment paused before the program could reach its capacity due to serious illnesses of a couple of nursing staff in the NFP team.

- **Parents as Teachers (PAT):** 62 members  
The capacity of UNM CDD and ENMRSH (the agency that contracts to provide services in Curry and Roosevelt counties) to provide the PAT HV services is 40 and 20 families, respectively. There were some members being discharged from the program. Both of the programs reached their maximum enrollments at the end of DY6 year.

HSD has worked with the New Mexico Children, Youth and Families Department (CYFD) to recruit new agencies who would contract with CYFD as well as serve as Medicaid CHV providers in a county-wide fashion to ensure that all NM families would not be denied HV services due to the lack of pay source, either because they are not eligible for Medicaid or because they lose Medicaid eligibility during their course of receiving HV services. In DY6, CYFD signed a memorandum of understanding with the Taos Pueblo to expand CHV services to Taos County in 2020. The Pueblo is working to become a Medicaid home visiting provider and to amend their contracts with the Centennial Care Managed Care Organizations.

### **Presumptive Eligibility Program**

The NM HSD Presumptive Eligibility (PE) program continues to be an important part of the State's efforts. Presumptive Eligibility Determiners (PEDs) are employees of qualified hospitals, clinics, FQHCs, IHS facilities, schools, primary care clinics, community organizations, County Jails and Detention Centers, and some NM State Agencies including the NM Department of Health (DOH), NM Children Youth and Families Department (CYFD) and the NM Corrections Department (NMCD). Currently, there are approximately 742 active certified PEDs state-wide. These PEDs provide PE screening, grant PE approvals, and assisting with on-going Medicaid application submissions.

Staff in the Medical Assistance Division's Communication and Education Bureau (CEB) conduct monthly PE Certification trainings for employees of qualified entities that chose to participate in the PE program. PE certification requirements include; active participation during the entire training session, completion of a post-training comprehension test, and submission of all required PED registration documents. For active PEDs, PE program staff conduct Your Eligibility System for New Mexico-Presumptive Eligibility (YESNM-PE) demo trainings. During demo trainings, the PEDs have the opportunity to take a refresher training on "How To" utilize the tools and resources available to them; specifically, the New Mexico Medicaid Portal and YESNM-PE to screen for PE, grant PE, and submit on-going Medicaid applications. PE program staff conducted seventeen PE certification trainings and sixteen YESNM-PE demo refresher trainings during DY6.

The table below outlines the numbers of PE approvals granted and the total number of ongoing applications submitted and approved. NM PEDs are aware of the importance of on-going Medicaid coverage for their clients. This is reflected by the high number of PE approvals that also had an ongoing application submitted in DY6 (99.13% of PE approvals also has an on-going Medicaid application submitted).

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**Table 10: PE Approvals**

PE APPROVALS (January – December 2019)				
MONTH	PE GRANTED	% PE GRANTED W / ON-GOING APPLICATION SUBMITTED	TOTAL INDIVIDUALS APPLIED	INDIVIDUALS APPROVED
Q1	656	99.24%	5289	4323
Q2	581	98.97%	4929	4002
Q3	581	99.66%	4867	3930
Q4	552	98.19	4579	3683
<b>Total</b>	<b>2370</b>	<b>99.13%</b>	<b>19,664</b>	<b>15,938</b>

**JUST HEALTH PROGRAM**

Certified PEDs employed at the New Mexico Corrections Department (NMCD) and County Jails or Detention Centers participate in the PE Program through the Justice-Involved Utilization of State Transitioned Healthcare (JUST Health) program.

The JUST Health program was established to ensure justice-involved individuals have timely access to healthcare services upon release from correctional facilities. To ensure this access can occur, individuals who have active Medicaid coverage at the time of incarceration do not lose their Medicaid eligibility, but rather, have their Medicaid benefits suspended after 30 days. Benefits are reinstated upon the individual’s release from incarceration which allows immediate access to care. Individuals who are not Medicaid participants but who appear to meet eligibility requirements are given the opportunity to apply while incarcerated. Application assistance is provided by PEDs at the correctional facilities.

It is HSD’s goal to reduce recidivism by ensuring that individuals have immediate access to services (i.e., prescriptions, transportation, Behavioral Health appointments, etc.) upon release. To help facilitate access to care and ensure smooth transitions from correctional facilities, HSD has established the Centennial Care JUST Health workgroup. The workgroup includes representatives from State and County Correctional facilities, Managed Care Organizations, County governments, State agencies, provider organizations and other stakeholders. The goal of the workgroup is to create a transition of care with detailed processes and procedures that can be utilized and adapted to work for all correctional facilities state-wide. During DY6 the JUST Health work group created a draft Transition of Care process that is currently getting reviewed to be finalized and implemented in correctional facilities in NM.

The following table outlines the numbers of PE approvals granted and the total number of ongoing applications submitted and approved. In DY6 97.12% of all PE approvals also had an ongoing application submitted.

**Table 11: PE Approvals**

PE APPROVALS (January – December 2019)				
MONTH	PEs GRANTED	% PE GRANTED W / ON-GOING APPLICATION SUBMITTED	TOTAL INDIVIDUALS APPLIED	INDIVIDUALS APPROVED
Q1	59	98.31%	483	454
Q2	22	90.91%	416	393
Q3	34	97.06%th	461	427
Q4	24	100.00%	438	409
<b>Total</b>	<b>139</b>	<b>97.12%</b>	<b>1,798</b>	<b>1,683</b>

**PUBLIC FORUM**

HSD held Medicaid Advisory Committee (MAC) meetings on April 15, 2019 and December 16, 2019.

The State looks forward to updating its Committee Members and public about its Centennial Care 2.0 program.



# 7

## HCBS REPORTING

Critical Incidents	
DY6 Activities	<p>HSD/MAD conducted quarterly meetings with Managed Care Organizations (MCOs), external stakeholders; Behavioral Health Services Division (BHSD) and Adult Protective Services (APS) to discuss critical incident reports (CIRs), reporting requirements and the use of the HSD/MAD Critical Incident Reporting Portal. HSD discussed with the MCOs their responsibility in completing mandatory follow-up activities to monitor members' health, safety and welfare, until there is no concern. The annual provider CIR trainings were conducted by the MCOs in September 2019.</p> <p>HSD/MAD conducted daily reviews of critical incidents submitted by MCOs and personal care providers for compliance with the reporting requirements.</p> <p>HSD/MAD provided daily assistance to MCOs, personal care providers, and behavioral health providers to obtain login in credentials to access the CIR Portal. HSD assisted with resetting login credentials and deleting duplicate reports.</p> <p>HSD provided MCOs weekly reports of identified critical incident reporting inaccuracies. The MCOs are to correct these errors and provide and update to HSD.</p>

**TOTAL CRITICAL INCIDENTS REPORTED**

(January – December 2019)

<b>M CO</b>	<b>CENTENNIAL CARE</b>	<b>BEHAVIORAL HEALTH</b>	<b>SELF DIRECTED</b>	<b>DY6 TOTAL</b>
BCBS	4,912	347	315	5,574
PHP	14,764	738	1,043	16,545
WSCC	1,039	68	72	1,179
Total	20,715	1,153	1,430	23,298

**BCBS**

(January – December 2019)

<b>CRITICAL INCIDENT TYPES</b>	<b>CENTENNIAL CARE</b>	<b>BEHAVIORAL HEALTH</b>	<b>SELF DIRECTED</b>	<b>DY6 TOTAL</b>
Abuse	245	47	16	308
Death	486	12	13	511
Elopement/Missing	19	6	7	32
Emergency Services	3,053	125	225	3,403
Environmental Hazard	58	2	2	62
Exploitation	86	10	7	103
Law Enforcement	62	13	6	81
Neglect	903	132	39	1,074
All Incident Types	4,912	347	315	5,574

**PHP**

(January – December 2019)

<b>CRITICAL INCIDENT TYPES</b>	<b>CENTENNIAL CARE</b>	<b>BEHAVIORAL HEALTH</b>	<b>SELF DIRECTED</b>	<b>DY6 TOTAL</b>
Abuse	650	110	44	804
Death	965	25	32	1,022
Elopement/Missing	25	6	1	32
Emergency Services	9,973	194	867	11,034
Environmental Hazard	265	17	18	300
Exploitation	144	11	14	169
Law Enforcement	138	30	9	177
Neglect	2,604	345	58	3,007
All Incident Types	14,764	738	1,043	16,545

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WSCC (January – December 2019)				
CRITICAL INCIDENT TYPES	CENTENNIAL CARE	BEHAVIORAL HEALTH	SELF DIRECTED	DY6 TOTAL
Abuse	82	12	7	101
Death	92	0	5	97
Elopement/Missing	7	3	0	10
Emergency Services	550	11	47	608
Environmental Hazard	25	1	1	27
Exploitation	16	0	2	18
Law Enforcement	6	1	1	8
Neglect	261	40	9	310
All Incident Types	1,039	68	72	1,179

### **Consumer Support Program**

The consumer support program is a system of organizations and state agencies 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.

Reporting for the quarter and YTD is provided by the Aging and Long-Term Services Department (ALTSD) - Aging and Disability Resource Center (ADRC). The ADRC is the single point of entry for older adults, people with disabilities, their families, and the broader public to access a variety of services

**Table 12: ADRC Hotline Call Profiler Report DY6 Q4**

ADRC HOTLINE CALL PROFILER REPORT (OCTOBER - DECEMBER 2019)	
TOPIC	NUMBER OF CALLS
Home/Community Based Care Waiver Programs	2,876
Long Term Care/Case Management	2
Medicaid Appeals/Complaints	3
Personal Care	210
State Medicaid Managed Care Enrollment Programs	9
Medicaid Information/Counseling	1,489

**Table 13: ADRC Care Transition Program Report DY6 Q4**

ADRC CARE TRANSITION PROGRAM REPORT (OCTOBER – DECEMBER 2019)			
COUNSELING SERVICES	NUMBER OF HOURS	NUMBER OF NURSING HOME RESIDENTS	NUMBER OF CONTACTS
Transition Advocacy Support Services		134	
*Medicaid Education/Outreach	2,027		
Nursing Home Intakes		55	
**LTSS Short-Team Assistance			47

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

\*\*Clients are provided short-term assistance in identifying and understanding their needs and to assist them in making informed decisions about appropriate long-term services and supports choices in the context of their personal needs, preferences, values and individual circumstances.

**Table 14: ADRC Hotline Call Profiler Report DY6**

ADRC HOTLINE CALL PROFILER REPORT (JANUARY - DECEMBER 2019)	
TOPIC	NUMBER OF CALLS
Home/Community Based Care Waiver Programs	12,317
Long Term Care/Case Management	18
Medicaid Appeals/Complaints	31
Personal Care	1,100
State Medicaid Managed Care Enrollment Programs	251
Medicaid Information/Counseling	4,785

**Table 15: ADRC Care Transition Program Report DY6**

ADRC CARE TRANSITION PROGRAM REPORT (JANUARY – DECEMBER 2019)			
COUNSELING SERVICES	NUMBER OF HOURS	NUMBER OF NURSING HOME RESIDENTS	NUMBER OF CONTACTS
Transition Advocacy Support Services		793	
*Medicaid Education/Outreach	9,523		
Nursing Home Intakes		354	
**LTSS Short-Team Assistance			774

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

\*\*Clients are provided short-term assistance in identifying and understanding their needs and to assist them in making informed decisions about appropriate long-term services and supports choices in the context of their personal needs, preferences, values and individual circumstances.

The ADRC/ALTSB provides services that support the Community Benefit (CB) program and transitions from Nursing Facilities (NFs) to the community. Below is a summary of ADRC/ALTSD activities, and assistance in continuous improvement projects.

**ADRC/ALTSD Activities**

- Held meetings with BCBS, PHP and WSCC to discuss Medicaid NF to community transitions.
- Participated in multiple Medicaid training and education events for staff at NFs and other facilities around New Mexico.
- Participated in outreach events providing Medicaid participants information about the application process, eligibility criteria and services provided by ALTSD.
- Made referrals and helped coordinate delivery of Medicaid services for acute, primary, mental health and Long-Term Services and Supports.
- Assisted applicants with the Medicaid eligibility process for Long-Term Care programs including education, documentation for eligibility, Medicaid applications, and identifying contact information.
- Interagency coordination to identify Medicaid service gaps, develop procedures to evaluate need for services and/or expand access to specific populations.
- Coordinated with HSD on initiatives to promote continuity of care.
- Conducted trainings with Centennial Care MCOs and providers on community-based resources and supports that could be linked with covered plan benefits.

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**Electronic Visit Verification (EVV)**

In DY6, MCOs and their subcontractors continued to provide assistance to Personal Care Services (PCS) agencies with the EVV system which included connectivity issues and billing as needed. HSD monitors the MCOs' EVV data through regular reporting. Please see EVV data for DY6 Q1-Q3 outlined in the table below. DY6 Q4 data will be provided in the DY7 Q1 report.

For DY6 Q3, the MCOs reported 75% of the total PCS claims were created by the Interactive Voice Response (IVR) phone system. The remainder of claims were created through the Authenticare app. Data for DY6 Q4 is not yet available.

In December 2019, HSD's good faith effort exemption request for the implementation of EVV for the Self-Directed Community Benefit (SDCB), and FFS programs was approved. HSD, MCOs, and subcontractors continue to work towards implementation of EVV for the SDCB and FFS programs by January 2021.

**Table 16: EVV DATA for Agency-Based Community Benefit PCS DY6 Q1-Q3**

EVV (JANUARY – SEPTEMBER 2019)		
MCO	AVERAGE NUMBER OF UNIQUE MEMBERS AUTHORIZED THIS PERIOD	NUMBER OF TOTAL CLAIMS THIS PERIOD
BCBS	6,597	1,265,054
PHP	14,142	2,759,457
WSCC	1,313	275,854
TOTAL	22,052	4,300,365

### ***Home and Community-Based Services Final Rule***

HSD continues to update the Statewide Transition Plan (STP) milestones as required by CMS. HSD also plans to finalize the STP and complete the public comment process by mid 2020. Once the public comment process including tribal notification is completed, HSD will resubmit the final STP to CMS.

### ***Nursing Facility Level of Care (NF LOC)***

HSD requires the MCOs to provide a summary of their internal audits of NF LOC Determinations. Each MCO conducts internal random sample audits of both Community Based and Facility Based determinations completed by their staff based on the HSD NF LOC Criteria and Instructions guidelines. The audit includes accuracy, timeliness, consistency and training of reviewers. The results and findings are reported quarterly to HSD along with any Quality Performance Improvement Plan. BCBS conducted 525 audits, PHP conducted 659, and WSCC conducted 217 audits of NF LOC Determinations during DY6.

The MCO conduct trainings, refresher trainings, staff coaching, and expectations for clinical documentation to ensure consistency throughout each review. The MCO internal reports track the number of reviewers audited each month; number and type of files (community-based/nursing facility) per reviewer; and identified trends and training/retraining completed quarterly/annually.

**Table 15 – Quarterly MCO Internal NF LOC Audit Report – Facility Based**

<b>Facility Based Internal Audits</b>	<b>DY6 Q1</b>	<b>DY6 Q2</b>	<b>DY6 Q3</b>	<b>DY6 Q4</b>
<b>High NF Determinations</b>				
<b>Total number of High NF LOC files audited</b>	<b>9</b>	<b>28</b>	<b>33</b>	<b>35</b>
BCBS	5	8	12	11
PHP	-	14	14	17
WSCC	4	6	7	7
<b>Total number with correct NF LOC determination</b>	<b>9</b>	<b>27</b>	<b>33</b>	<b>32</b>
BCBS	5	7	12	9
PHP	-	14	14	17
WSCC	4	6	7	6
<b>%</b>	<b>100%</b>	<b>96%</b>	<b>100%</b>	<b>91%</b>
BCBS	100%	88%	100%	81%
PHP	-	100%	100%	100%
WSCC	100%	100%	100%	95%
<b>Low NF Determinations</b>				
<b>Total number of Low NF LOC files audited</b>	<b>34</b>	<b>44</b>	<b>38</b>	<b>42</b>
BCBS	19	16	12	11
PHP	5	16	16	16
WSCC	10	12	10	15
<b>Total number with correct NF LOC determination</b>	<b>34</b>	<b>42</b>	<b>38</b>	<b>42</b>
BCBS	19	14	12	11
PHP	5	16	16	16
WSCC	10	12	10	15
<b>%</b>	<b>100%</b>	<b>95%</b>	<b>100%</b>	<b>100%</b>
BCBS	100%	88%	100%	100%
PHP	100%	100%	100%	100%
WSCC	100%	100%	100%	100%
<b>Timeliness of Determinations</b>				
<b>Total number of High NF LOC determinations completed within required timeframes</b>	<b>9</b>	<b>26</b>	<b>33</b>	<b>34</b>
BCBS	5	8	12	11
PHP	-	13	14	16
WSCC	4	5	7	7
<b>%</b>	<b>100%</b>	<b>93%</b>	<b>100%</b>	<b>97%</b>
BCBS	100%	100%	100%	100%
PHP	-	93%	100%	93%
WSCC	100%	83%	100%	100%
<b>Total number of Low NF LOC determinations completed within required timeframes</b>	<b>34</b>	<b>41</b>	<b>38</b>	<b>41</b>
BCBS	19	16	12	11
PHP	5	14	16	15
WSCC	10	11	10	15
<b>%</b>	<b>100%</b>	<b>93%</b>	<b>100%</b>	<b>98%</b>
BCBS	100%	100%	100%	100%
PHP	100%	89%	100%	93%
WSCC	100%	92%	100%	100%

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**Table 16 – Quarterly MCO Internal NF LOC Audit Report – Community Based**

<b>Community Based Internal Audits</b>		<b>DY6 Q1</b>	<b>DY6 Q2</b>	<b>DY6 Q3</b>	<b>DY6 Q4</b>
<b>Total number of Community Based NF LOC files audited</b>		<b>124</b>	<b>328</b>	<b>323</b>	<b>306</b>
BCBS		74	112	98	90
PHP		28	174	182	177
WSCC		22	42	43	39
<b>Total number with correct NF LOC determination</b>		<b>124</b>	<b>328</b>	<b>321</b>	<b>306</b>
BCBS		74	112	97	90
PHP		28	174	181	177
WSCC		22	42	43	39
<b>%</b>		<b>100%</b>	<b>100%</b>	<b>99%</b>	<b>100%</b>
BCBS		100%	100%	99%	100%
PHP		100%	100%	99%	100%
WSCC		100%	100%	100%	100%
<b>Timeliness of Determinations</b>					
<b>Total number of Community Based determinations completed within required timeframes</b>		<b>107</b>	<b>300</b>	<b>322</b>	<b>305</b>
BCBS		61	91	98	90
PHP		28	168	181	176
WSCC		18	41	43	39
<b>%</b>		<b>86%</b>	<b>91%</b>	<b>100%</b>	<b>100%</b>
BCBS		83%	82%	100%	100%
PHP		100%	97%	99%	99%
WSCC		79%	98%	100%	100%

**External Quality Review (EQRO) Nursing Facility (NF) Level of Care (LOC):**

HSD has contracted with the EQRO to conduct an MCO NF LOC determination audit. The goal of the audit is to ensure the contracted MCOs are applying the state-specified NF LOC criteria equitably and as directed by HSD.

HSD requires MCOs to report the EQRO a monthly breakdown of the NF LOC determinations/redeterminations completed during the quarter. The report consists of the number of NF LOC determinations completed, the number of determinations that were completed timely; the number of assessments completed where the member did not meet the state-specified NF LOC criteria, and the number of NF LOC determinations/redeterminations completed within the required timeframes.

The EQRO requests a sampling of the total NF LOC determinations/redeterminations files completed during the month. The EQRO conducts a file review applying the state-specified criteria to determine the NF LOC. The EQRO compares the determinations with those of the MCO and concludes an agreement or disagreement with the determinations made by the MCO on the NF LOC.

**Table 17: EQRO Annual MCO NF LOC Determinations- Facility Based**

Facility Based Determinations					
HIGH NF Determinations	Q1	Q2	Q3	Q4	DY6
<b>Total number of determinations/redeterminations completed for High NF LOC requests</b>	<b>174</b>	<b>184</b>	<b>255</b>	<b>236</b>	<b>849</b>
BCBS	29	43	55	76	203
PHP	131	131	163	134	559
WSCC	14	10	37	26	87
<b>Total number of determinations/redeterminations that met High NF LOC criteria</b>	<b>152</b>	<b>164</b>	<b>215</b>	<b>194</b>	<b>725</b>
BCBSNM	29	43	55	60	187
PHP	109	111	123	108	451
WSCC	14	10	37	26	87
<b>Percent of determinations/redeterminations that met High NF LOC criteria</b>	<b>87%</b>	<b>89%</b>	<b>84%</b>	<b>82%</b>	<b>85%</b>
BCBSNM	100%	100%	100%	79%	92%
PHP	83%	85%	75%	81%	81%
WSCC	100%	100%	100%	100%	100%
Low NF Determinations	Q1	Q2	Q3	Q4	DY6
<b>Total number of determinations/redeterminations completed for Low NF LOC requests</b>	<b>1404</b>	<b>1358</b>	<b>1269</b>	<b>1394</b>	<b>5425</b>
BCBS	346	424	439	483	1692
PHP	979	857	718	825	3379
WSCC	79	77	112	86	354
<b>Total number of determinations/redeterminations that met Low NF LOC criteria</b>	<b>1378</b>	<b>1326</b>	<b>1220</b>	<b>1322</b>	<b>5246</b>
BCBS	346	424	439	460	1669
PHP	953	825	669	776	3223
WSCC	79	77	112	86	354
<b>Percent of determinations/redeterminations that met Low NF LOC criteria</b>	<b>98%</b>	<b>98%</b>	<b>96%</b>	<b>95%</b>	<b>97%</b>
BCBS	100%	100%	100%	95%	99%
PHP	97%	96%	93%	94%	95%
WSCC	100%	100%	100%	100%	100%
Timeliness Determinations	Q1	Q2	Q3	Q4	DY6
<b>Total number of High NF LOC determinations/redeterminations completed within required timeframes</b>	<b>96</b>	<b>110</b>	<b>130</b>	<b>157</b>	<b>493</b>
BCBS	12	21	17	56	106
PHP	72	81	84	78	315
WSCC	12	8	29	23	72
<b>Percent of High NFLOC determinations/redeterminations completed within required timeframes</b>	<b>55%</b>	<b>60%</b>	<b>51%</b>	<b>67%</b>	<b>58%</b>
BCBS	41%	49%	31%	74%	52%
PHP	55%	62%	52%	58%	56%
WSCC	86%	80%	78%	88%	83%
<b>Total number of Low NF LOC determinations/redeterminations completed within required timeframes</b>	<b>982</b>	<b>1109</b>	<b>1064</b>	<b>1192</b>	<b>4347</b>
BCBS	279	331	355	448	1413
PHP	638	711	600	661	2610
WSCC	65	67	109	83	324
<b>Percent of Low NF LOC determinations/redeterminations completed within required timeframes</b>	<b>70%</b>	<b>82%</b>	<b>84%</b>	<b>86%</b>	<b>80%</b>
BCBS	81%	78%	81%	93%	84%
PHP	65%	83%	84%	80%	77%
WSCC	82%	87%	97%	97%	92%

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**Table 18: EQRO Annual MCO NF LOC Determinations- Community Based**

Community Based Determinations		Q1	Q2	Q3	Q4	DY6
<b>Total number of determinations/redeterminations completed</b>		<b>6508</b>	<b>8097</b>	<b>6782</b>	<b>6075</b>	<b>27462</b>
BCBS		1096	2640	1796	1605	7137
PHP		4805	5040	4530	4145	18520
WSCC		607	417	456	325	1805
<b>Total number of determinations/redeterminations that met NF LOC criteria</b>		<b>6181</b>	<b>7821</b>	<b>6572</b>	<b>5870</b>	<b>26444</b>
BCBS		1096	2640	1796	1586	7118
PHP		4486	4769	4325	3974	17554
WSCC		599	412	451	310	1772
<b>Percent of determinations/redeterminations that met NF LOC criteria</b>		<b>95%</b>	<b>97%</b>	<b>97%</b>	<b>97%</b>	<b>96%</b>
BCBS		100%	100%	100%	99%	100%
PHP		93%	95%	95%	96%	95%
WSCC		99%	99%	99%	95%	98%
Timeliness of Determinations		Q1	Q2	Q3	Q4	DY6
<b>Total number of determinations/redeterminations completed within required timeframes</b>		<b>2694</b>	<b>5912</b>	<b>6662</b>	<b>5999</b>	<b>21267</b>
BCBS		891	2484	1783	1590	6748
PHP		1400	3111	4453	4092	13056
WSCC		403	317	426	317	1463
<b>Percent of determinations/redeterminations completed within required timeframes</b>		<b>41%</b>	<b>73%</b>	<b>98%</b>	<b>99%</b>	<b>77%</b>
BCBS		81%	94%	99%	99%	95%
PHP		29%	62%	98%	99%	70%
WSCC		66%	76%	93%	98%	81%

Throughout DY6, HSD followed up on EQRO determination disagreements identified in prior reporting periods to maintain high levels of accuracy and to identify areas of improvement. HSD also conducted annual analyses for DY6 and requested that the EQRO adjust sampling methodology to increase the number of denied cases that were reviewed. HSD will continue to monitor the EQRO audit of MCO NF LOC determinations to identify and address any trends and provide technical assistance to the MCOs as needed.

# 8

## AI/ AN REPORTING

MCO	Date of Board Meeting	Issues/Recommendations
BCBS	Office of Dine Youth Shiprock, New Mexico October 17, 2019	<p>This Native American Advisory Board (NAAB) meeting was in Navajo as well as English. The meetings have been reorganized in a new format of six 10-minute breakout sessions.</p> <ul style="list-style-type: none"> <li>• Recommendations from the group were to have more time for breakout sessions and have more meetings.</li> <li>• This NAAB meeting was translated in the Zuni language.</li> <li>• The recommendations given at the meeting included a request for a monthly newsletter in the community and training for services to be provided locally.</li> <li>• Recommendations from the meeting were to use microphones or a quieter site, name tags for presenters, if a member chooses to share a story don't censor them about violating HIPAA, and have more peer support specialists at the meetings.</li> <li>• Recommendations from the feedback forms included: longer breakout sessions, a little longer group sessions, and that stakeholders like the way the meeting is set up for behavioral services.</li> </ul>

PHP	Cooper Center, PHP Albuquerque, NM November 8, 2019	<ul style="list-style-type: none"> <li>• A member expressed concern that their medical transportation provider had body odor. The member completed a complaint to address the issue. PHP will follow up.</li> <li>• The question was asked if the Durable Medical Equipment (DME) provider carried upright walkers. The response was that it is no longer a covered benefit.</li> </ul>
WSCC	Taylor Ranch Community Center Albuquerque, New Mexico November 16, 2019	Feedback consisted of questions about language assistance and transportation services, value added benefits such as the traditional healing benefit, and for WSCC to provide a reminder call about the Native American Advisory Board.

**Table 19: Status of Contracting with MCOs**

MCO	Status
BCBS	<p>BCBS remains open to contracting discussions with IHS/Tribal 638/Urban Indian (I/T/U) provider partners; however, they have not been successful in contracting any new I/T/U providers in 2019. The Navajo Area IHS is the largest non-contracted I/T/U provider group not contracted with BCBS. The federal template is under review internally by BCBS. BCBS will continue to reach out at least once per month to determine if the status has changed.</p>
PHP	<p>PHP makes every effort to contract with all the I/T/Us and Tribal programs in the State of New Mexico. With respect to Tribal Leadership and honoring Tribal sovereignty, they tailor their agreements to meet each Tribe’s goals and needs for their community. They are utilizing Mutual Partnership Agreements (MPAs) and Letters of Agreement (LOAs) to strengthen collaborative efforts and improve Native American member’s ability to access culturally competent healthcare and to respect their choice of IHS as their primary care.</p> <p>PHP continues to meet with I/T/Us to provide information about PHPs Value Based Purchasing (VBP) arrangements and identify potential interest to participate in an incentive program and develop into a delegated care coordination arrangement. With IHS and Tribal facilities they explain the uniqueness of the Tribal Entity Initiatives VBP arrangement. PHP explains how they will collaborate with them to customize the program to meet their goals and the needs of their community and provide technical assistance and support to prepare them to participate in the program to achieve success.</p> <p>PHP also continues to meet with Community Health Representative (CHR) programs to discuss CHR reimbursement arrangements and are working with those programs that are interested in developing agreements to assist with care coordination activities such as health risk assessments, transportation, and translation for their members.</p>

WSCC	<p>Western Sky Community Care (WSCC) Tribal Relations Department staff continue their outreach with New Mexico Tribes, Tribal health boards, Tribal Community Health Representatives (CHR), Indian Health Service hospitals and clinics on the services and benefits provided through WSCC health plan. No new agreements were entered into in the fourth quarter of 2019. WSCC Native American staff developed a draft Professional Service Agreement (PSA) for CHR programs with the Mescalero Apache and with Santo Domingo Pueblo. WSCC anticipates completing the projects in the next quarter. The Tribal CHR programs will perform care coordination, health risk assessments, patient transportation and translation services for WSCC members residing on reservations. WSCC Tribal Relations and Contracting staff continue to meet with programs to make amendments to existing signed agreements and assist programs to create contracting documents. WSCC Native American Provider Relations staff continue outreach and education to Tribal officials in Tribal communities and at Tribal meetings. They also met with the Albuquerque Area Indian Health Service to discuss data and information sharing and established an agreement to meet on a quarterly basis in 2020 to discuss billing and claims issues, provider rosters, contracting and other topics of mutual interest.</p>
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# 9

## ACTION PLANS FOR ADDRESSING ANY ISSUES IDENTIFIED

BLUE CROSS BLUE SHIELD	
<b>ACTION PLAN</b>	Remediate Care Coordination Audit Findings
<b>IMPLEMENTATION DATE:</b>	7/19/2016
<b>COMPLETION DATE:</b>	Open Item
<b>ISSUES</b>	Overall care coordination with focus on improved practices following the record review and the onsite review
<b>RESOLUTION</b>	<p>The CNA compliance rate for DY6 has improved from 72% in Q1 to 87% in Q4. BCBS leadership team continues to audit initial CNAs to ensure appropriate compliance.</p> <p>For Action Step 1, BCBS conducted internal audits to ensure that members enrolled in waiver categories who have a CNA indicating they meet criteria for CCL2 or CCL3 are assigned to the correct care coordination level. In DY6 BCBS showed significant improvement in the leveling of members, with compliance increasing from 56% in Q1 to 92% in Q3. BCBS attributed the increase in compliance to a dedicated 1915(c) waiver team, re-training of all BCBS care coordinators and continual, weekly training on stratification for team members. In Q3, BCBS created a weekly report capturing stratification on all Medically Fragile (095) and Developmentally Disabled (095) waiver members which has allowed for closer monitoring. BCBS will continue to conduct quarterly audits and HSD will conduct audits to confirm the reported results in DY7 Q2.</p> <p>For Action Step 2, BCBS conducted internal audits to ensure that member files met compliance for “easily understood language” in all Notice of Adverse Determination letters. BCBS met compliance in DY6 Q2 and Q3. BCBS has included the “easily understood” requirement on their Policy and Procedures Job Aid and has conducted follow up trainings with Medical Directors regarding language-level requirements. HSD closed this Action step in DY6 Q4.</p>



BLUE CROSS BLUE SHIELD	
<b>ACTION PLAN</b>	Care Coordination Activities
<b>IMPLEMENTATION DATE:</b>	12/21/2018
<b>COMPLETION DATE:</b>	Open Item
<b>ISSUES</b>	<p>This action plan includes the following areas requiring improvement:</p> <ol style="list-style-type: none"> <li>1. Compliance of care coordination activities (timeliness and clinical appropriateness) with HRA/CNA/NF LOC –<b>Closed</b> (CY19 Q1, BCBS updated processes for conducting HRAs and CNAs timely, improved the auditing of care coordinators work related to timeliness and re-training staff on the updated processes and revised audit tool. BCBS is finalizing workflows for oversight of Delegated Care Coordination entities. BCBS is currently working with PMS to be contracted as a DCCE and an effective date not yet been determined.)</li> <li>2. Staff Training Evaluation/ Effectiveness Plan</li> <li>3. Reporting</li> <li>4. Burndown Plan – <b>Closed</b> (HRA backlog completed 12/31/18, CNA and NFLOC backlog completed on 4/22/19.)</li> </ol>
<b>RESOLUTION</b>	<p>The BCBS Oversight Action Plan continues to be internally monitored weekly to document progress towards resolution of open items (Action Items 2 and 3).</p> <p>The Healthcare Management and reporting teams meet regularly to discuss refining operational reports in order to enhance the management of the care coordinators workload. A process document related to staff training and an effectiveness plan was developed. A mechanism to track post knowledge and training results is being discussed and will be included in the plan that has been drafted.</p>

BLUE CROSS BLUE SHIELD	
<b>ACTION PLAN</b>	PCP Auto Assignment
<b>IMPLEMENTATION DATE:</b>	4/25/2019
<b>COMPLETION DATE:</b>	Open Item
<b>ISSUES</b>	BCBS identified an issue with PCP assignments for Centennial Care transition members. The enrollment system typically flags new members for auto-assignment; however, the members did not get flagged as “new”, causing the auto-assign process to skip these members in the normal process.
<b>RESOLUTION</b>	80 percent of the of the functionality needed to support PCP auto assignment was completed by the November deadline. BCBS is working on the remaining 20 percent, with a new timeline of 4/1/2020.

BLUE CROSS BLUE SHIELD	
<b>ACTION PLAN</b>	Nurse Advice Line
<b>IMPLEMENTATION DATE:</b>	7/1/2019
<b>COMPLETION DATE:</b>	Open Item
<b>ISSUES</b>	The Nurse Advice Line failed to meet the “85 percent of calls answered within 30 seconds” service level call metric.
<b>RESOLUTION</b>	BCBS is monitoring the metric of calls answered within 30 seconds. The October metric was 84.8 percent, November was 86 percent and December was 90 percent. The increase is due to a strategy change in which a dedicated team now has responsibility specific to answer these calls. BCBS anticipates the metric to stabilize and to meet the requirement going forward.

BLUE CROSS BLUE SHIELD	
<b>ACTION PLAN</b>	Report 6- Care Coordination Metrics (CNAs & CCPs)
<b>IMPLEMENTATION DATE:</b>	9/13/2019
<b>COMPLETION DATE:</b>	Closed
<b>ISSUES</b>	<p>BCBS's CY19 Q2 Report 6 submission.</p> <p>BCBS has not meet all benchmarks for completion within contract timeframes for:</p> <ul style="list-style-type: none"> <li>• Comprehensive Care Plans (CCPs)</li> <li>• Comprehensive Needs Assessments (CNAs)</li> </ul>
<b>RESOLUTION</b>	In DY6 Q3, BCBS successfully closed out the open action items and this remediation was closed on 12/17/2019. The final remediation plan was submitted to HSD on 12/18/19. BCBS continues to monitor these metrics regularly.

BLUE CROSS BLUE SHIELD	
<b>ACTION PLAN</b>	Logisticare
<b>IMPLEMENTATION DATE:</b>	11/01/2019
<b>COMPLETION DATE:</b>	Open Item
<b>ISSUES</b>	LogistiCare failed to meet the 85% threshold for the total Calls answered within 30 seconds and the Member Satisfaction metric of 90% for the month of September.
<b>RESOLUTION</b>	BCBS proactively implemented the remediation plan on 11/1/2019 as Logisticare did not meet the calls answered within 30 seconds for Q3 and member satisfaction for September. Logisticare completed the necessary adjustments and met the call center metric for Q4, therefore, this line item is closed. However, the member satisfaction metric for December was 88.1 percent and was not met so this line item remains open. BCBS will continue to monitor the open line item related to member satisfaction.

PRESBYTERIAN HEALTH PLAN	
<b>ACTION PLAN</b>	Vision Service Plan (VSP): Utilization Management Audit Area
<b>IMPLEMENTATION DATE:</b>	9/26/2018
<b>COMPLETION DATE:</b>	Open Item
<b>ISSUES</b>	Annual Audit, 9/20/18 Annual Audit, 9/26/19
<b>RESOLUTION</b>	<p>PHP will be requiring an Improvement Plan or a Corrective Action Plan when the final report is released for Claims, Provider Network, and Appeals and Grievances. The IT &amp; Reporting portion of the audit is in process. PHP is awaiting additional documents from VSP.</p> <p>PHP is conducting its annual audit. Audit is in process.</p>

PRESBYTERIAN HEALTH PLAN	
<b>ACTION PLAN</b>	Superior Medical Transportation (SMT)
<b>IMPLEMENTATION DATE:</b>	3/29/2019 (Improvement Plan in process)
<b>COMPLETION DATE:</b>	Open Item
<b>ISSUES</b>	Improvement Plan- wheelchair access issues
<b>RESOLUTION</b>	<p>Measure: Ensure all members requiring wheelchair transportation are transported to and from appointments via appropriate wheelchair vehicles to meet members transportation needs.</p> <p>Goal: 100 percent compliant</p> <p>SMT continues to monitor areas in need of wheelchair coverage. Per SMT, there are no new companies in New Mexico with wheelchair accessible vehicles. In addition, SMT reported that they have been unsuccessful in getting Contracted Transportation Providers (CTPs) to expand coverage and increase wheelchair vehicles. CTPs have expressed concern of maintenance and insurance of wheelchair vehicles and are not willing to increase the fleet at this time.</p>

PRESBYTERIAN HEALTH PLAN	
<b>ACTION PLAN</b>	Superior Medical Transportation (SMT)
<b>IMPLEMENTATION DATE:</b>	5/13/2019
<b>COMPLETION DATE:</b>	Open Item
<b>ISSUES</b>	Improvement Plan- Transportation provider no-shows
<b>RESOLUTION</b>	<p>Measure: Ensure all members are picked up for their appointments and return home transports</p> <p>Goal: 100 percent compliant</p> <p>From July 2019 through November 2019, SMT has reduced provider no shows by 48%.</p> <p>July – 107</p> <p>August – 78</p> <p>September – 67</p> <p>October – 55</p> <p>November - 55</p>

PRESBYTERIAN HEALTH PLAN	
<b>ACTION PLAN</b>	DentaQuest
<b>IMPLEMENTATION DATE:</b>	10/4/2019
<b>COMPLETION DATE:</b>	Open Item
<b>ISSUES</b>	Annual Audit, May 23, 2019
<b>RESOLUTION</b>	<p>A. Administrative &amp; Compliance Audit = 100 percent</p> <p>B. Financial Audit = 100 percent</p> <p>C. Claims Timeliness and Claims Accuracy = 100 percent</p> <p>D. Provider Network = 100 percent</p> <p>E. Credentialing = 100 percent</p> <p>F. Utilization Management</p> <p>1) File Review = 100 percent</p> <p>2) Administrative Review = 95 percent</p>

**RESOLUTION  
(continued)**

Improvement Plan required for the following items:

- a. UM 2B - PHP requires DentaQuest to develop and submit documentation describing a process for routine oversight by Dental Consultants of the accuracy and appropriateness of medical necessity approval determinations completed by non-licensed clinicians. DentaQuest must also provide documentation describing the licensed clinical staff responsible for day-to-day supervision of UM staff, participation in staff training, monitoring for consistent application of criteria for each level and type of UM decision, monitoring documentation for adequacy, and being available to UM staff on site or by telephone.
- b. UM 4F- This element requires submission of a policy and procedure for utilizing Dental Consultants. The consultant list provided in the rebuttal does not cover the list of specialties indicated in the program description reference, nor is it clear in the documentation that the consultants are board-certified. Additionally, DentaQuest did not provide any case files showing evidence of use of board-certified consultants. The request for a remediation plan to be submitted remains and should include the development of a policy and procedure, a formal list of consultants available including identification of certifying board and inclusion of all necessary specialties, and how use of board-certified consultants is documented in case files and identifiable for audits.
- c. UM Templates- DentaQuest failed to accurately implement the templates received, resulting in the required reference to the Centennial Care approval number not being present on the letter. PHP does not accept DentaQuest's plan to await receipt of new templates from PHP as the pending templates are not related to this finding.

Update: In December 2019, PHP staff met with DentaQuest to discuss PHP's request for an Improvement Plan. Following the meeting, it was agreed that DentaQuest will provide an Improvement Plan and required documents to PHP on or before 12/18/2019.

G. Appeals & Grievances Audit = 100 percent

H. IT & Reporting = 100 percent

I. Fraud, Waste and Abuse = 100 percent

WESTERN SKY COMMUNITY CARE	
<b>ACTION PLAN</b>	<b>Noncompliance by Transportation Vendor</b>
<b>IMPLEMENTATION DATE:</b>	<b>12/6/2019</b>
<b>COMPLETION DATE:</b>	<b>Open Item</b>
<b>ISSUES</b>	On 12/6/2019, WSCC issued a Notice of Noncompliance and Request for Corrective Action Plan (CAP) to its subcontractor, Secure Transportation, for failure to meet formatting, timeliness, and accuracy requirements for encounter submissions.
<b>RESOLUTION</b>	Secure Transportation initiated the CAP on 12/27/2019. WSCC requested that Secure Transportation make significant progress at remediating the issues within 30 days of implementation. WSCC will assess Secure Transportation's progress at the end of January 2020. If marked improvements are not demonstrated, WSCC will request a Quality Improvement Plan and/or impose other penalties as allowed per their agreement with Secure Transportation.

# 10

## FINANCIAL/ BUDGET NEUTRALITY DEVELOPMENT/ISSUES

DY6 Q4 reflects the new capitation rates for Centennial 2.0 that were submitted to the Centers for Medicare and Medicaid on December 28, 2018, rate update for April 1, 2019 for full contracting with the teaching hospital, and rate updates for July 1, 2019 and October 1, 2019. The result is higher PMPMs for DY 6 compared to those of DY 5 for MEGs 1, 2, 5 and 6; the PMPMs of DY 6 are lower than those of DY 5 for MEGs 3 and 4 (see Attachment A – Budget Neutrality Monitoring, Table 3 - PMPM Summary by Demonstration Year and MEG). On Attachment A – Budget Neutrality Monitoring Spreadsheet – Budget Neutrality Limit Analysis shows DY 6 is 3.1% below the budget neutrality limit (Table 6.5) through four quarterly payments.

### **Summary of Plan Financial Performance for DY6**

In DY6, HSD monitored MCO contractual compliance for insolvency and performance bond coverage. All three MCOs remained in good standing by maintaining an account balance equal to no less than ninety (90%) of the average monthly capitation paid to the MCO in the most recent quarter. Also, MCOs remained compliant with Fidelity bond requirements. To limit the MCOs' risk of catastrophic losses and its exposure to large claims by individuals with chronic or high cost conditions, the MCOs maintained a minimum of one-million dollars (\$1,000,000) per member in reinsurance protection. The reinsurance pays a percentage of losses in excess of the deductible; 9 members met the reinsurance deductible in CY19.

HSD has provisions in the Centennial Care contract which allows for recoupment of capitation payments made for members who were incorrectly enrolled with more than one MCO, members who die prior to the enrollment month for which a capitation payment was made and members whom HSD later determines were not eligible for Medicaid during the enrollment month for which a capitation payment was made. HSD also processes mass adjustments for capitation payments issued at a non-dual rate cohort and then reissued at a dual rate cohort for members who are retroactively determined to have Medicare coverage and do not exceed the time period that the MCO can retroactively adjust claims payment to providers for those services for which Medicare would be the primary payer. The recoupments and adjustments are processed monthly. In CY18, HSD added the recoupment of capitation payments for individuals who are Medicaid enrolled and have their benefits suspended after 30 days of incarceration. At the end of CY19, 0.3% of total capitation payments were recouped from the MCOs because of the issues mentioned above. The initial payment or recoupment for the CY17 Retroactive Period, Patient Liability and Hepatitis C Risk Corridor Reconciliations were processed with final evaluations scheduled to be completed January 1, 2019 – December 31, 2023



early CY20 along with IHS reconciliations. After completing the reconciliations, the evaluation of underwriting gain earned by each MCO for the contract period will be performed.

During DY5 Q3, United Health Care Community Plan (UHC) terminated its participation in the Centennial Care Medicaid Program. On September 1, 2018, UHC transitioned approximately 86,000 members to Presbyterian Health Plan (PHP) as a result of a Medicaid membership buy out. UHC submitted all required financial reports for CY18. HSD has completed all required reconciliations and has successfully transitioned UHC out of the Centennial Care program. Molina HealthCare (MHC) was not selected as a Centennial Care 2.0 MCO. HSD has developed a termination plan with MHC and continues to work with MHC as necessary through the run-out period of financial reporting. Final closeout with MHC is scheduled for the end of CY20. All MCOs are required to submit their CY19 fourth quarter financial reports on February 15, 2020. Reviews will be completed with observations and questions being sent to the MCOs for response and review of the categorization of service logic within their reporting. HSD continues to focus attention on categorization of expenditures by program, cohort and category of service and the comparison of submitted encounter data to financial reports. Final CY19 annual supplement financial reports are due on May 15, 2020. HSD continues to evaluate the MCOs financial and operational performance at both the individual MCO level and an aggregate level.

# 11

## MEMBER MONTH REPORTING

Member Months		2019
		4
MEG1	0-FFS	108,525
	Presbyterian	544,908
	Western Sky	92,311
	Blue Cross Blue Shield	328,258
	<b>Total</b>	<b>1,074,002</b>
MEG2	0-FFS	7,379
	Presbyterian	60,722
	Western Sky	10,396
	Blue Cross Blue Shield	33,948
	<b>Total</b>	<b>112,445</b>
MEG3	Presbyterian	68,070
	Western Sky	7,046
	Blue Cross Blue Shield	31,215
	<b>Total</b>	<b>106,331</b>
MEG4	0-FFS	320
	Presbyterian	355
	Western Sky	43
	Blue Cross Blue Shield	289
	<b>Total</b>	<b>1,007</b>
MEG5	Presbyterian	7,026
	Western Sky	761
	Blue Cross Blue Shield	5,113
	<b>Total</b>	<b>12,900</b>
MEG6	0-FFS	76,974
	Presbyterian	370,228
	Western Sky	61,624
	Blue Cross Blue Shield	267,585
	<b>Total</b>	<b>776,411</b>
<b>Total</b>		<b>2,083,096</b>
	<b>Total</b>	<b>756,331</b>
<b>Total</b>		<b>2,052,824</b>

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# 12

## CONSUMER ISSUES

### **Grievances**

HSD/MAD reviewed the MCOs Grievances which are submitted on a monthly basis and the data is categorized into two top primary Member Grievance codes: (1) Transportation Ground Non-Emergency and (2) Other Specialties. The results from the monthly Grievance data are aggregated for a year total and reported below:

GRIEVANCES REPORTED (JANUARY – DECEMBER 2019)			
GRIEVANCES	BCBS	PHP	WSCC
Number of Member Grievances	1,764	1,420	221
Top Two Primary Member Grievance Codes			
Transportation Ground Non-Emergency	1,221	501	81
Other Specialties	67	30	10
Variable Grievances	476	889	130

### **Appeals**

HSD/MAD reviewed the MCOs Member Appeals which are submitted on a monthly basis and the data is categorized into two appeal codes: (1) Standard Member Appeals (2) Member Expedited Appeals. The results from the monthly Appeals data are aggregated for a year total and reported below in the appeals reported table.

In addition, HSD/MAD reviewed the MCOs Appeals which are submitted on a monthly basis and the data is categorized into two top primary Member Appeals codes: (1) Denial or limited authorization of a requested service (2) Reduction of authorized service. The results from the monthly Appeals data are aggregated for a year total and reported below:

<b>APPEALS REPORTED (JANUARY – DECEMBER 2019)</b>			
<b>A P P E A L S</b>	<b>BCBS</b>	<b>P H P</b>	<b>W S C C</b>
Number of Standard Member Appeals	1,004	2,033	114
Number of Expedited Member Appeals	311	19	22

<b>APPEALS REPORTED (JANUARY – DECEMBER 2019)</b>			
<b>A P P E A L S</b>	<b>BCBS</b>	<b>P H P</b>	<b>W S C C</b>
Top Two Primary Member Appeal Codes			
Denial or limited authorization of a requested service	892	1,794	124
Reduction of a previously authorized service	75	210	11
Variable Appeals	348	48	1

# 13

## QUALITY ASSURANCE/ MONITORING ACTIVITY

### Advisory Board Activities

Under the terms of HSD's Centennial Care 2.0 Managed Care Services Agreements and the Managed Care Policy Manual, the MCOs are required to convene and facilitate a Native American Advisory Board and a Member Advisory Board to advise on service delivery, the quality of covered services, and member needs, rights, and responsibilities. HSD specifies the frequency of board meetings. The MCOs report semi-annually on the activities of the Advisory Boards. Please reference Table 20: 2019 MCO Advisory Board Meeting Schedules below.

**Table 20: 2019 MCO Advisory Board Meeting Schedules**

BCBS 2019			
MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	DATE	TIME	LOCATION
BCBS	3/21/2019	12:00 PM	Special Collections Library, Albuquerque, NM
BCBS	6/13/2019	12:00 PM	Adelante Development Center Inc., Albuquerque, NM
BCBS	9/19/2019	12:00 PM	Adelante Development Center Inc., Albuquerque, NM
BCBS	12/12/2019	12:00 PM	South Valley Multi-Purpose Senior Center, Albuquerque, NM
STATEWIDE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	DATE	TIME	LOCATION
BCBS	2/27/2019	12:00 PM	Frank O'Brien Papen Center, Las Cruces, NM
BCBS	7/11/2019	12:00 PM	Clovis Carver Public Library, Clovis, NM
NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE			
MCO	DATE	TIME	LOCATION
BCBS	2/7/2019	12:00 PM	Navajo Technical University, Crownpoint, NM
BCBS	4/17/2019	12:00 PM	Zuni Wellness Center, Zuni, NM
BCBS	7/25/2019	12:00 PM	Native American Community Academy, Albuquerque, NM
BCBS	10/17/2019	12:00 PM	Shiprock Chapter House, Shiprock, NM

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**SDBC SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE**

<b>MCO</b>	<b>DATE</b>	<b>TIME</b>	<b>LOCATION</b>
BCBS	See above	See above	All above locations (SDCB included in each meeting)

**BH SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE**

<b>MCO</b>	<b>DATE</b>	<b>TIME</b>	<b>LOCATION</b>
BCBS	See above	See above	All above locations (SDCB included in each meeting)

**PHP 2019**

**MEMBER ADVISORY BOARD MEETING SCHEDULE**

<b>MCO</b>	<b>DATE</b>	<b>TIME</b>	<b>LOCATION</b>
PHP	3/8/2019	11:00 AM	Presbyterian Cooper Administrative Center, Albuquerque NM
PHP	6/7/2019	11:00 AM	Presbyterian Cooper Administrative Center, Albuquerque NM
PHP	9/6/2019	11:00 AM	Presbyterian Cooper Administrative Center, Albuquerque NM
PHP	12/6/2019	11:00 AM	Presbyterian Cooper Administrative Center, Albuquerque NM

**STATEWIDE MEMBER ADVISORY BOARD MEETING SCHEDULE**

<b>MCO</b>	<b>DATE</b>	<b>TIME</b>	<b>LOCATION</b>
PHP	9/6/2019	11:00 AM	La Posta Restaurant, Mesilla NM 88046
PHP	12/6/2019	11:00 AM	La Cueva Restaurant, Taos NM 87581

**NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE**

<b>MCO</b>	<b>DATE</b>	<b>TIME</b>	<b>LOCATION</b>
PHP	3/8/2019	11:00 AM	Crownpoint Chapter House, Crownpoint NM
PHP	4/26/2019	11:00 AM	Espanola Presbyterian Hospital, Espanola, NM
PHP	8/2/2019	11:00 AM	San Juan College, Farmington NM
PHP	11/8/2019	11:00 AM	Presbyterian Cooper Administrative Center, Albuquerque


### BH SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE

MCO	DATE	TIME	LOCATION
PHP	3/12/2019	1:00 PM	Presbyterian Cooper Administrative Center, Albuquerque NM
PHP	6/11/2019	1:00 PM	Presbyterian Cooper Administrative Center, Albuquerque NM
PHP	9/10/2019	1:00 PM	Presbyterian Cooper Administrative Center, Albuquerque NM

### WSCC 2019

#### MEMBER ADVISORY BOARD MEETING SCHEDULE

MCO	DATE	TIME	LOCATION
WSCC	1/23/2019	5:30 PM	Las Cruces Convention Center, Las Cruces, NM
WSCC	4/10/2019	5:30 PM	CNM Workforce Training Center, Albuquerque, NM
WSCC	7/11/2019	5:30 PM	Hobbs Public Library, Hobbs, NM
WSCC	10/11/2019	11:00 AM	Española Public Library, Española, NM
WSCC	12/18/2019	11:30 AM	Albuquerque Public Library, Albuquerque, NM

#### STATEWIDE MEMBER ADVISORY BOARD MEETING SCHEDULE

MCO	DATE	TIME	LOCATION
WSCC	1/23/2019	5:30 PM	Las Cruces Convention Center, Las Cruces, NM
WSCC	7/11/2019	5:30 PM	Hobbs Public Library, Hobbs, NM
WSCC	10/11/2019	11:00 AM	Española Public Library, Española, NM

#### NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE

MCO	DATE	TIME	LOCATION
WSCC	1/9/2019	11:00 AM	Gallup Community Service Center, Gallup, NM
WSCC	3/27/2019	5:00 PM	San Juan Community Center, Farmington, NM
WSCC	7/18/2019	1:00 PM	Santa Clara Senior Center, Santa Clara, NM
WSCC	11/15/2019	5:30 PM	Taylor Ranch Community Center, Albuquerque, NM



### SDBC SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE

MCO	DATE	TIME	LOCATION
WSCC	6/22/2019	4:30 PM	Munson Senior Center, Las Cruces, NM

### BH SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE

MCO	DATE	TIME	LOCATION
WSCC	10/9/2019	4:30 PM	Española Public Library, Española, NM

#### Quality Assurance

##### DY6 Activities

HSD requires each contracted MCO to comply with state and federal standards of Quality Management and Quality Improvement (QM/QI). The MCO contract requires the development of a QM/QI program that focuses on continuous quality improvement and applies clinically sound and nationally developed criteria. The QM/QI model developed is required to provide mechanisms that guide the quality of healthcare services and to detect over and underutilization of services provided to the States Medicaid beneficiaries. Each contracted MCO is required to submit an annual QM/QI program description and workplan (HSD #22) as well and an QM/QI annual evaluation (HSD #23) which include policies and procedures developed to define the goals and objectives of the QM/QI plan.

The MCO contract defines the HSD required performance measures (PM), tracking measures (TM) and performance improvement projects (PIPs) that focus on the quality, timeliness and access of services provided under the Centennial Care 2.0 contract.

**Performance Measures Monitoring:**

The DY6 Centennial Care 2.0 contract mandated the MCOs meet the HSD established PM targets which required the MCO to meet a two (2) percentage point improvement above the MCO's prior years audited Health Effectiveness Data and Information Set (HEDIS) reported rate; or achievement of the prior year Health and Human Services (HHS) Regional Average. All PMs and targets are based on the National Committee for Quality Assurance (NCQA) HEDIS technical specifications for CY19 and the 2019 Quality Compass report. HSD imposes monetary penalties for PMs that do not meet the established targets. The final audited HEDIS reports for CY19

will be submitted on June 30<sup>th</sup>, 2020 at which time HSD will determine if the MCOs met the PM targets established for DY6 and what monetary penalties will be assessed. The PMs are validated annually by the EQRO in accordance with the CMS EQR Protocol #2 as part of the mandatory EQR validation of PMs. The following PMs were required for DY6:

- PM #1 - Well Child Visits (W15);
- PM #2 - Children and Adolescents' Access to Primary Care (CAP);
- PM #3 - Adult BMI Assessment (ABA);
- PM #4 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children /Adolescents (WCC);
- PM #5 - Comprehensive Diabetes Care (CDC);
- PM #6 - Prenatal and Postpartum Care (PPC);
- PM #7 - Antidepressant Medication Management (AMM);
- PM #8 - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET); and
- PM #9 - and Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC).

**Tracking Measures:**

In DY6, HSD directed the MCOs to report and monitor 10 tracking measures via a quarterly report submission on an HSD prescribed reporting template. The quarterly reports for each MCO were reviewed for accuracy and appropriateness. The data was analyzed and compared to previous quarterly report submissions and the MCOs annual audited HEDIS results for CY18. HSD provided feedback to the MCOs on findings that indicated the MCO and aggregate results from the year-to-date DY6 reports were compared to aggregate results from the DY5 reports. The following TM were reported for DY6:

- TM #1 - Fall Risk Management;
- TM #2 – Diabetes, Short Term Complications Admission Rate;
- TM #3 – Screening for Clinical Depression and Follow up Plan;
- TM #4 – Follow up after Hospitalization for Mental Illness
- TM #5 - Immunization for Adolescents;
- TM #6 – Long Acting Reversible Contraception (LARC);
- TM #7 – Smoking Cessation;
- TM #8 – Ambulatory care;
- TM #9 – Annual Dental Visits;
- TM #10 – Controlling High Blood pressure;

HSD observed positive findings for TMs reported in both DY6 and DY5 with performance improvements for; Fall Risk Management, Screening for Clinical Depression and Follow up Plan, and Smoking Cessations. HSD also compared year to date results to CY18 annual audited HEDIS results and observes the improvements to Annual Dental Visits and Immunizations for Adolescents.

**Performance Improvement Projects (PIPs)**

In DY6, HSD required each MCO to implement five (5) PIPs. The MCOs are guided to develop the PIPs in accordance with CMS, External Quality Review (EQR) protocol 3, and are encouraged to design the PIPs to target relevant clinical or non-clinical services that are specific to their individual member population. The MCO aim for each PIP is to meet the unique needs of the members, to ensure sustainable improvements and interventions, and to focus on quality improvement. The MCO PIPs are validated annually by the EQRO as part of the EQR mandatory validation of PIPs.

Three (3) PIPS focused on the following areas: one (1) Long Term Care Services, one (1) Prenatal and Postpartum, and one (1) Adult Obesity. For these PIPs the MCOs are given the opportunity to select their individual study groups and study indicators.

Two (2) State directed PIPs, one (1) that focused on prevention and enhanced disease management for diabetes, that required two (2) study indicators; diabetes short-term complications admission rate, and Hemoglobin A1c testing, and one (1) for screening and management for clinical depressions, also requiring two (2) study indicators; antidepressant medication management, and screening for clinical depression and follow-up plan.

The following are the CY19 PIPs submitted by the MCO's PIPs are validated annually by the EQRO as part of the EQR mandatory validation.

**BCBS**

Long Term Services and Supports (LTSS): BCBS sought to increase diabetic retinal eye exam compliance for LTSS members diagnosed with diabetes.

Prenatal and Postpartum: BCBS's objective is to increase the rate of compliance with timely prenatal and postpartum care for

	<p>members who have had a live birth.</p> <p>Adult Obesity: BCBS's aim for this PIP is to increase the rate of annual body mass index (BMI) assessments in members 18 years of age and older.</p> <p>Diabetes Management: BCBS objectives consisted of decreasing the rate of inpatient re-admissions for diabetes related to short-term complications for members 18 years of age and older and increasing the rate of compliance of HbA1c testing for adult members who were diagnosed with diabetes.</p> <p>Screening and Management for Clinical Depression: BCBS aimed to increase the rate of engagement of adult members identified as needing a fill/refill for antidepressant medication for more than 6 months, and to promote depression screening and the reporting of screening outcomes to providers, which would likely improve percentages of members being screened for depression.</p> <p><b>PHP</b></p> <p>Long Term Services and Supports: PHP's "Transition of Care Community Reintegration" PIP aims are to improve the percent of members reintegrating to the community from a nursing facility.</p> <p>Prenatal and Postpartum: PHP's objective of this PIP is to determine if participation in the Baby Benefits program reduces preventable pregnancy complications by encouraging routine prenatal and postpartum care. The program provides educational material, postpartum reminder calls and referrals to care coordination for high risk members.</p> <p>Adult Obesity: PHP implemented a CDC recognized "Good Measure Diabetes Prevention Program to reduce both weight as well as developing type 2 diabetes.</p> <p>Diabetes Management: PHP's objective related to this PIP is to reduce the number of diabetes short-term complications admissions by increasing the HbA1c testing compliance for diabetic members through outreach and targeted case management for members diagnosed with a diagnosis of diabetes.</p> <p>Screening and Management for Clinical Depression: For this PIP PHP implemented a collaborative care model to improve antidepressant medication Management for members who were screened positive for clinical depression.</p> <p><b>WSCC</b></p> <p>Long Term Services and Supports: WSCC's aim is to improve the rates of fall-related hospitalizations and potentially preventable emergency room visits for LTSS members 60 years of age and older</p>
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	<p>living in the community. WSCC refers members to participate in the Department of Health’s “A Matter of Balance” program which is a community intervention class, led by a certified coach, designed to reduce the fear of falling and increase physical activity.</p> <p>Prenatal and Postpartum: WSCC’s objective for this PIP is to implement the Addiction in Pregnancy Program to improve the rate of initiating treatment for pregnant members 13 years of age and older who a diagnosed of alcohol or another drug abuse (AOD).</p> <p>Adult Obesity: WSCC developed the “Adult Weight Management Program” aimed at increasing the number of members, 19 years of age and older, who experienced a reduction in BMI.</p> <p>Diabetes Management: WSCC implemented a Diabetes Prevention and Management Program aimed at improving the HbA1c testing rate of members diagnosed with type 1 or type 2 diabetes, and to reduce the rate of admissions related to diabetes short-term complications.</p> <p>Screening and Management for Clinical Depression: WSCC’s objective for this PIP is to implement the Management for Clinical Depression program intended to improve the rates of members 18 years of age and older with major depression who were considered to have remained on antidepressant medication for at least 84 days and who remained on antidepressant medication for at least 180 days.</p> <p><b>Quarterly Quality Meetings:</b>  HSD conducted four (4) quarterly Quality meetings with the MCOs. HSD presented findings and analysis of aggregate CY18 MCO HEDIS result relevant to Performance Measures (PM) and Tracking Measures (TM). HSD also reviewed findings of the CAHPS survey conducted in CY17. The MCOs were advised of upcoming changes to the Performance Measures as well as the Delivery System Improvement Performance Targets (DSIPTs). HSD provided guidance and clarification to the MCOs regarding Quality Improvement Quality Management programs and reporting methodologies.</p> <p><b>Child, Adult and Health Home Core Set Reporting:</b>  On December 27th of DY6 HSD successfully completed the annual entry for 21 of the 33 Adult, 17 of the 31 Child and 7 of the 10 Health Home Core Set quality measures into the Centers for Medicare and</p>
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Medicaid (CMS) enterprise portal MACPro.

**External Quality Review Organization (EQRO):**

HSD is contracted with Island Peer Review Organization (IPRO) to perform EQRO activities. HSD participated in weekly calls with IPRO to review the status of all External Quality Review (EQR) activities with the MCOs and to discuss matters related to the current and future external quality review projects and activities.

EQRO activities consisted of the final revision of the CY17 MCO Compliance Review and the CY17 Performance Improvement Projects validation. HSD has reviewed all 2018 EQRO draft report deliverables and working with IPRO to make the corrections to the draft reports. HSD is in review of the EQRO tools and reviewing work plans for the 2019 upcoming audits.

**CY18 PM Conclusions:**

HSD received the MCO CY18 audited HEDIS reports on June 30, 2019 during DY6. The preliminary findings of the External Quality Review Organization (EQRO) Performance Measure (PM) Validation provided the following information with comparisons made to the HHS regional averages from CY17 to CY 18. Each MCO was required to demonstrate a two (2) percentage point improvement above the CY17 HEDIS rate or demonstrate achievement of the 2018 Quality Compass Health and Human Services (HHS) Dallas Regional Averages for CY17. MCO failure to meet an HSD target resulted in a financial penalty.

The data reported represents aggregated results from three (3) MCOs and individual MCO results for each Performance Measure:

PM 1 – Annual Dental Visits (ADV): The aggregate total rate of all three MCOS increased from 67.48% (CY17) to 71.27% (CY18), which confirmed a 5.6% increase from CY17. All three (3) MCOs met the HSD established target.

- BCBS demonstrated a rate of 67.90%, which improved by 3.52 percentage points above the CY17 HEDIS rate of 64.38%, but did not meet the HHS Dallas Regional Average of 69.57%
- MHC demonstrated a rate of 74.61%, which was above the HHS Dallas Regional Average of 69.57%

PHP demonstrated a rate of 71.31%, which was above the HHS Dallas Regional Average of 69.57%

PM 2 – Medication Management for People with Asthma: The aggregate total rate of all (3) three MCOs increased from 57.23% (CY17) to 59.65% (CY18), which confirmed a 4.2% increase from CY17. All three (3) MCOs met the HSD established target.

- BSBC demonstrated a rate of 59.42%, which improved by 7.90 percentage points above the CY17 HEDIS rate of 51.52%.
- MHC demonstrated a rate of 58.82%, which improved by 3.72 percentage points above the CY17 HEDIS rate of 55.10%
- PHP demonstrated a rate of 60.73%, which improved by 3.26 percentage points above the CY17 HEDIS rate of 57.47%

PM 3 – Controlling High Blood Pressure: The aggregate total rate for all (3) three MCOs increased from 49.88% (CY17) to 50.44% (CY18), which confirmed a 1.1% increase from CY17. All three (3) MCOs met the HSD established target.

- BSBC demonstrated a rate of 48.66%, which improved by 3.16 percentage points above the CY17 HEDIS rate of 45.50% and was also above the HHS Dallas Regional Average of 44.85%
- MHC demonstrated a rate of 46.47%, which was above the HHS Dallas Regional Average of 44.85%
- PHP demonstrated a rate of 56.20%, which improved by 7.54 percentage points above the CY17 HEDIS rate of 48.66% and was also above the HHS Dallas Regional Average of 44.85%

PM 4 – Comprehensive Diabetes Care:

-HbA1c Testing: The aggregate total rate for all 3 (three) MCOs decreased from 85.81%(CY17) to 84.89% (CY18), which confirmed a 1.07% decrease from CY17. 2 (two) of the 3 (three) MCOs met the HSD established target.

- BSBC demonstrated a rate of 82.97%, which failed to increase 2 (two) percentage points from CY17 HEDIS rate of 82.00% (.97 percentage point increase) and failed to meet HHS Dallas Regional Average of 84.51%.

- MHC demonstrated a rate of 86.86%, which was above the HHS Dallas Regional Average of 84.51%
- PHP demonstrated a rate of 84.85%, which was above the HHS Dallas Regional Average of 84.51%

-HbA1c Poor Control: The aggregate total rate for all 3 (three) MCOs increased from 48.31% (CY17) to 48.50% (CY18), which confirmed a 0.39% increase from CY17 (Lower rate indicates better performance.) All three (3) MCOs met the HSD established target.

- BSBC demonstrated a rate of 50.61%, which was below HHS Dallas Regional Average of 52.77%.
- MHC demonstrated a rate of 48.18%, which was below HHS Dallas Regional Average of 52.77%
- PHP demonstrated a rate of 46.72%, which was a decrease of 2.73 percentage points below the CY17 HEDIS rate of 49.45% and was below HHS Dallas Regional Average of 52.77%.

-Retinal Eye Exam: The aggregate total for all 3(three) MCOs increased from 54.91% (CY17) to 56.85% (CY18), which confirmed a 3.53% increase. All three (3) MCOs met the HSD established target.

- BCBS demonstrated a rate of 53.77%, which was a 2.68 percentage point increase above the CY17 HEDIS rate of 51.09% and above the HHS Dallas Regional Average of 52.09%
- MHC demonstrated a rate of 62.77%, which was a 2.43 percentage point increase above the CY17 HEDIS rate of 60.34% and above the HHS Dallas Regional Average of 52.09%
- PHP demonstrated a rate of 54.01%, which was a 2.00 percentage point rate increase above the CY17 HEDIS rate of 52.01% and above the HHS Dallas Regional Average of 52.09%.

-Nephropathy Screening: The aggregate total for all 3 (three) MCOs increased from 87.71% (CY17) to 87.91% (CY18), which confirmed a 0.22% increase. 2 (two) of the 3 (three) MCOs met the HSD established target.

- BCBS demonstrated a rate of 88.56%, which was a 2.19 percentage point increase above the CY17 HEDIS rate of 86.37% but did not meet the HHS Dallas Regional Average of



89.62%

- MHC demonstrated a rate of 89.78%, which was above HHS Dallas Regional Average of 89.62%
- PHP demonstrated a rate of 85.40%, which failed to increase 2 (two) percentage points from CY17 HEDIS rate of 86.13% (.73 percentage point decrease) and failed to meet the HHS Dallas Regional Average of 89.62%.

PM 5 – Prenatal and Post-partum Care:

-Timeliness of Prenatal Care: The aggregate total for all 3 (three) MCOs increased from 73.04% (CY17) to 76.61% (CY18), which confirmed a 4.89% increase. All three (3) MCOs met the HSD established target.

- BSBC demonstrated a rate of 80.78%, which was a 2.19 percentage point increase above the CY17 HEDIS rate of 78.59% but did not meet the HHS Dallas Regional Average of 82.28%.
- MHC demonstrated a rate of 75.43%, which was a 2.08 percentage point increase above the CY17 HEDIS rate of 73.35% but did not meet the HHS Dallas Regional Average of 82.28%.
- PHP demonstrated a rate of 73.63%, which was a 2.26 percentage point increase above the CY17 HEDIS rate of 71.36% but did not meet the HHS Dallas Regional Average of 82.28%.

-Postpartum Care: The aggregate total for all 3 (three) MCOs increased from 8.44% from 57.22% (CY17) to 62.05%(CY18), which confirmed an 8.44% increase. All three (3) MCOs met the HSD established target.

- BCBS demonstrated a rate of 63.50, which was a 2.43 percentage point increase above the CY17 HEDIS rate of 61.07% and met the HHS Dallas Regional Average of 63.32%.
- MHC demonstrated a rate of 59.85%, which was a 7.53 percentage point increase above the CY17 HEDIS rate of 52.32% but did not meet the HHS Dallas Regional Average of 63.32%.
- PHP demonstrated a rate of 62.81%, which was a 3.51 percentage point increase above the CY17 HEDIS rate of 59.30% but did not meet the HHS Dallas Regional Average of 63.32%.

PM 6 – Frequency of ongoing Prenatal Care: Discontinued (retired HEDIS measure in 2017) MCOs were not required to report on this measure for CY18.

PM 7 – Antidepressant Medication Management:

-Effective Acute Phase Treatment: The aggregate total for all 3 (three) MCOS increased from 49.12% (CY17) to 50.83% (CY18), which confirmed a 3.48% increase. 2 (two) of the 3 (three) MCOs met the HSD established target.

- BSBS demonstrated a rate of 49.12%, which failed to increase 2 (two) percentage points from CY17 HEDIS rate of 47.81% (1.31 percentage increase) and failed to meet HHS Dallas Regional Average of 51.29%.
- MHC demonstrated a rate of 49.62%, which was a 3.85 percentage point increase above the CY17 HEDIS rate of 45.77% but did not meet the HHS Dallas Regional Average of 51.29%.
- PHP demonstrated a rate of 53.74%, which was a 3.51 percentage point increase above the CY17 HEDIS rate of 50.59% and met the HHS Dallas Regional Average of 51.29%.

-Effective Continuation Phase Treatment: The aggregate total for all 3 (three) MCOs increased from 33.73%(CY17) to 33.84% (CY18), which confirmed a 0.33% increase, one of the 3 (three) MCOs met the HSD established target.

- BCBS demonstrated a rate of 32.79%, which failed to increase 2 (two) percentage points from CY17 HEDIS rate of 32.59% (0.20 percentage point increase) and failed to meet HHS Dallas Regional Average of 35.71%
- MHC demonstrated a rate of 32.34%, which failed to increase 2 (two) percentage points from CY17 HEDIS rate of 30.54% (1.80 percentage point increase) and failed to meet HHS Dallas Regional Average of 35.71%
- PHP demonstrated a rate of 36.40%, which was a 2.09 percentage point increase from CY17 HEDIS rate of 34.31% but did not meet the HHS Dallas Regional Average of 35.71%

PM 8 – Follow-Up After Hospitalization for Mental Illness: This PM was previously reported based on HEDIS technical specifications. For CY18, BHSD modified the technical specifications to include other behavioral health practitioners, peer support services, etc.,

and HSD is pending EQRO validation of metrics reported by the MCOs for CY18. As shown in Table 21:

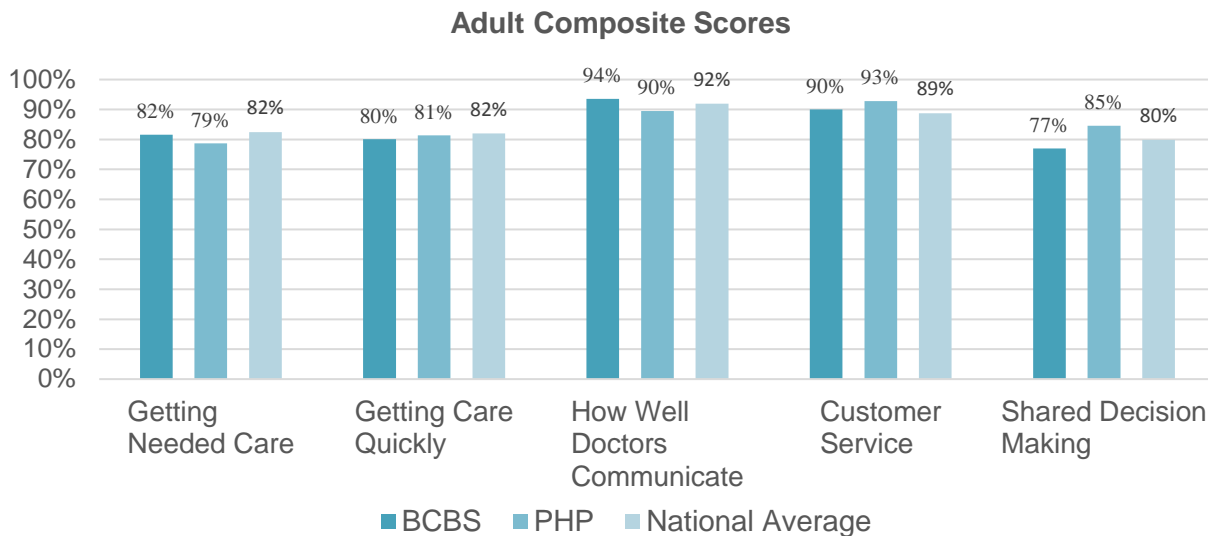
**Table 21: Performance Measures HEDIS Rates (2018)**

Measure	BCBS CY 2018 Rate	MHC CY 2018 Rate	PHP CY 2018 Rate	HHS Dallas Regional Average
<b>PM 1 Annual Dental Visits</b>	67.90%	74.61%	71.31%	69.57%
<b>PM 2 Medication Management for People with Asthma (50%)</b>	59.42%	58.82%	60.73%	N/R
<b>PM 3 Controlling High Blood Pressure</b>	48.66%	46.47%	56.20%	44.85%
<b>PM 4 Comprehensive Diabetes Care</b>				
HbA1c Test	82.97%	86.86%	84.85%	84.51%
HbA1c Poor Control (lower is better)	50.61%	48.18%	46.72%	52.77%
Retinal Eye Exam	53.77%	62.77%	54.01%	52.09%
Nephropathy	88.56%	89.78%	85.40%	89.62%
<b>PM 5 Prenatal and Postpartum Care</b>				
Timeliness	80.78%	75.43%	73.62%	76.61%
Postpartum Care	63.50%	59.85%	62.81%	62.05%
<b>PM 6 Frequency of Prenatal Care (HEDIS retired measure)</b>	Discontinued	Discontinued	Discontinued	N/R
<b>PM 7 Antidepressant Medication Management</b>				
Acute	49.12%	49.62%	53.74%	51.29%
Continuation	32.79%	32.34%	36.40%	35.71%
<b>PM 8 FUH</b>				
6-17 Years of Age	Not Validated	Not Validated	Not Validated	Not Applicable
18+ Years of Age	Not Validated	Not Validated	Not Validated	Not Applicable

## CAHPS SURVEY

Centennial Care MCOs are required to submit the Consumer Assessment of Healthcare Providers and Systems (CAHPS) report on an annual basis with data collected from the prior year on adults, children, and children with chronic conditions (CCC). The report was submitted by the MCOs to NCQA in June of 2019 with CY 2018 data. HSD worked with the MCOs to ensure inclusion of survey questions that would capture data for specific components of Centennial Care. Only two MCOs, BCBS and PHP, reported CAHPS results for the 2019 survey (CY 2018 data), as both UHC and MHP exited Centennial Care in 2018. Results of the 2019 CAHPS survey with CY 2018 data were compared to the 2019 National Committee for Quality Assurance (NCQA) Quality Compass national average established using CY 2018 data.

The graph below reflects the percentages of the MCOs compared to the CY 2018 national average for the adult composite scores.

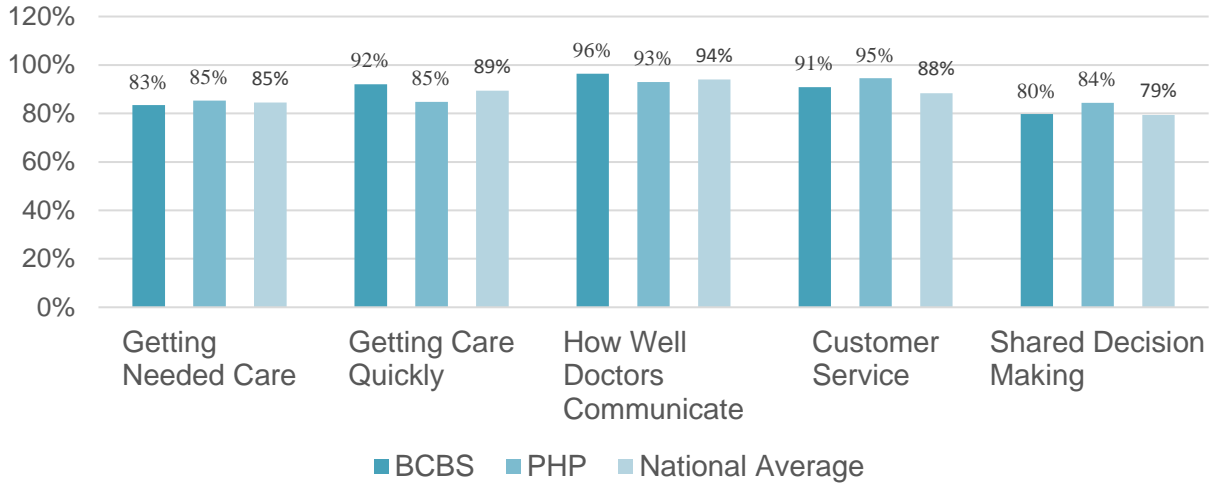


### Conclusions:

BCBS met the national average for “Getting Needed Care”. Neither of the two MCOs met the national average for “Getting Care Quickly”. BCBS was above the national average for “How Well Doctors Communicate”. PHP was above the national average for “Customer Service”. PHP was above the national average for “Shared Decision Making”.

The graph below reflects the percentages of the MCOs compared to the Cy 2018 national average for the child composite scores:

### Child Composite Scores

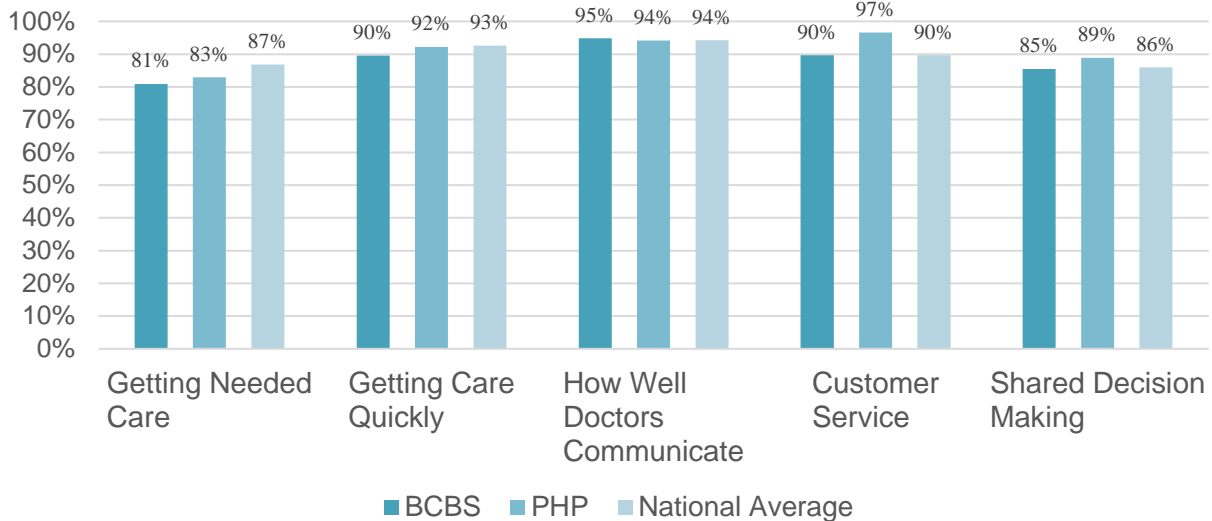


#### Conclusions:

PHP met the national average for “Getting Needed Care”. BCBS was above the national average for “Getting Care Quickly”. BCBS was above the national average for “How Well Doctors Communicate”. Both BCBS and PHP were above the national average for “Customer Service and “Shared Decision Making”.

The graph below reflects the percentages of the MCOs compared to the CY 2018 national average for the CCC composite scores:

### CCC Composite Scores



#### Conclusions:

Neither of the two MCOs met the national average for the “Getting Needed Care” or “Getting Care Quickly”. BCBS and PHP were at or above the national average for “How Well Doctors

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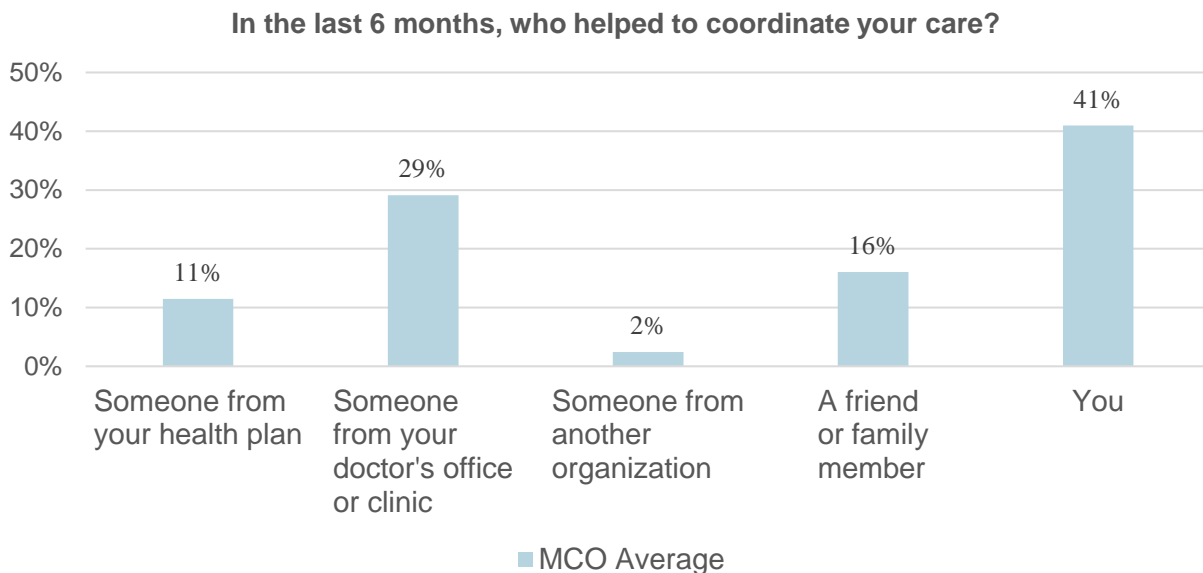
Communicate” and “Customer Service”. PHP was above the national average for “Shared Decision Making”.

In addition to the standard CAHPS 5.0 survey questions, HSD required the MCOs to include fourteen (14) additional questions that were approved by the National Committee Quality Assurance (NCQA) for the 2019 CAHPS survey. To review the complete CAHPS results, please visit the HSD website at:

<http://www.hsd.state.nm.us/LookingForInformation/2016-cahps-reports.aspx>

### NCQA Approved Additional Care Coordination Questions (Adult)

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



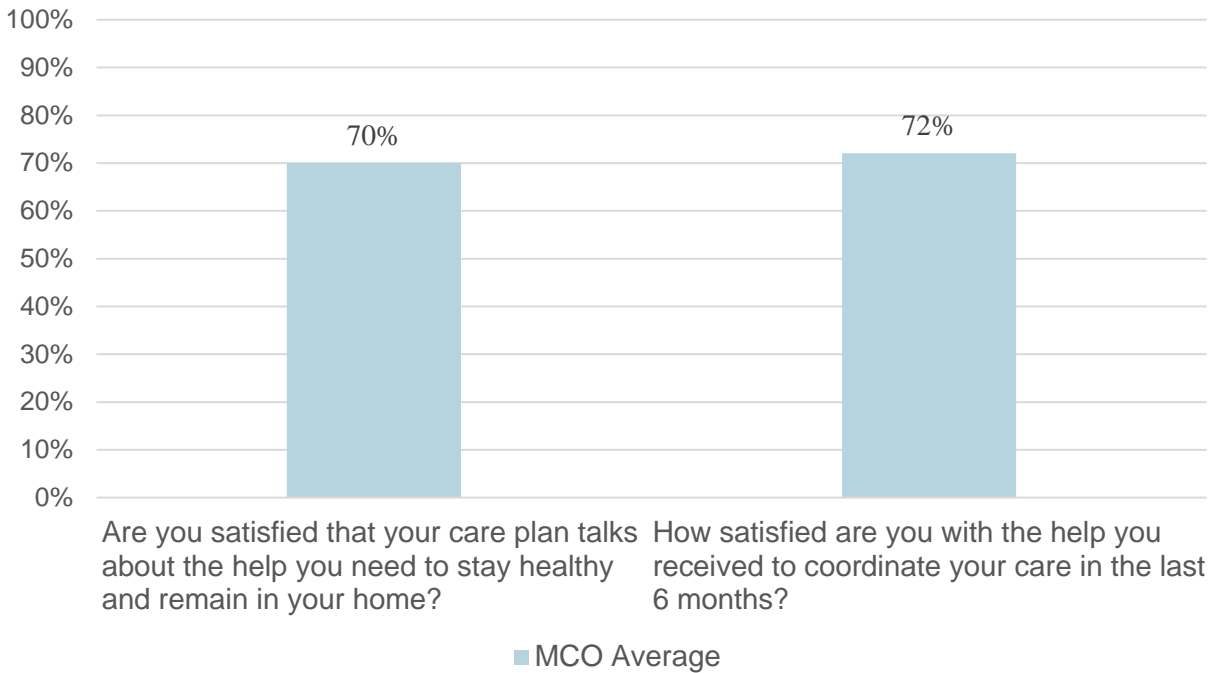
#### Conclusion:

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

### NCQA Approved Additional Member Satisfaction Questions (Adult)

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

**Adult Care Plan/Care Coordination - Percent Answering "Satisfied or Very Satisfied"**

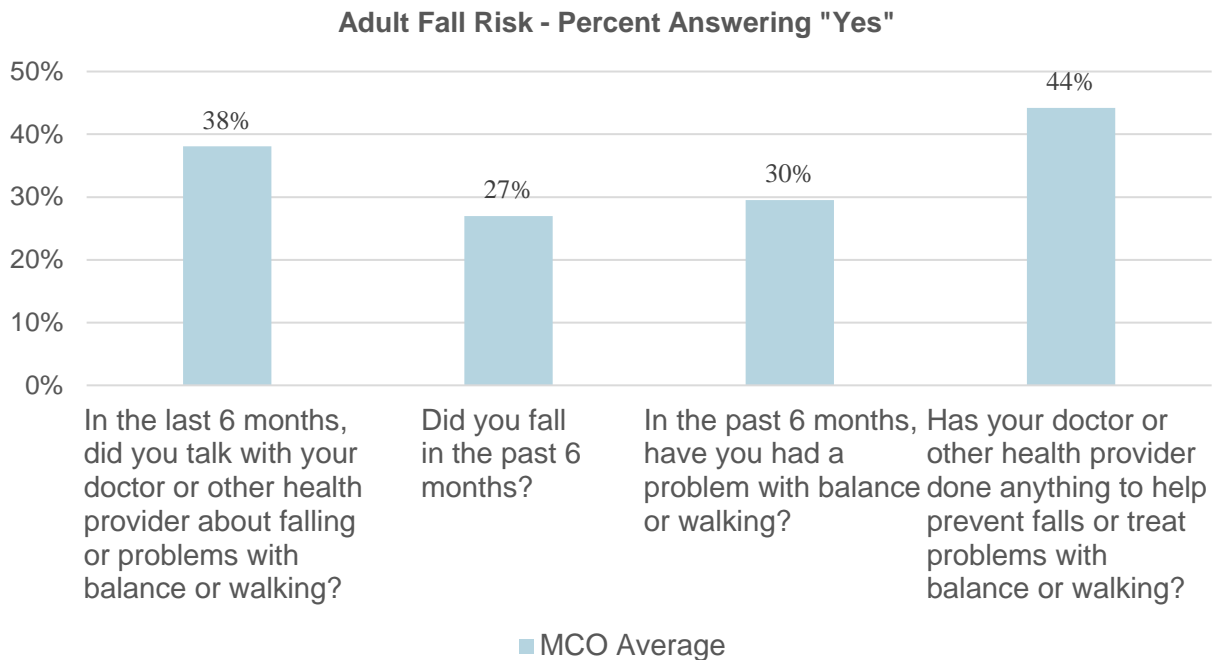


**Conclusions:**

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

**NCQA Approved Additional Questions Fall Risk (Adult)**

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



**Conclusions:**

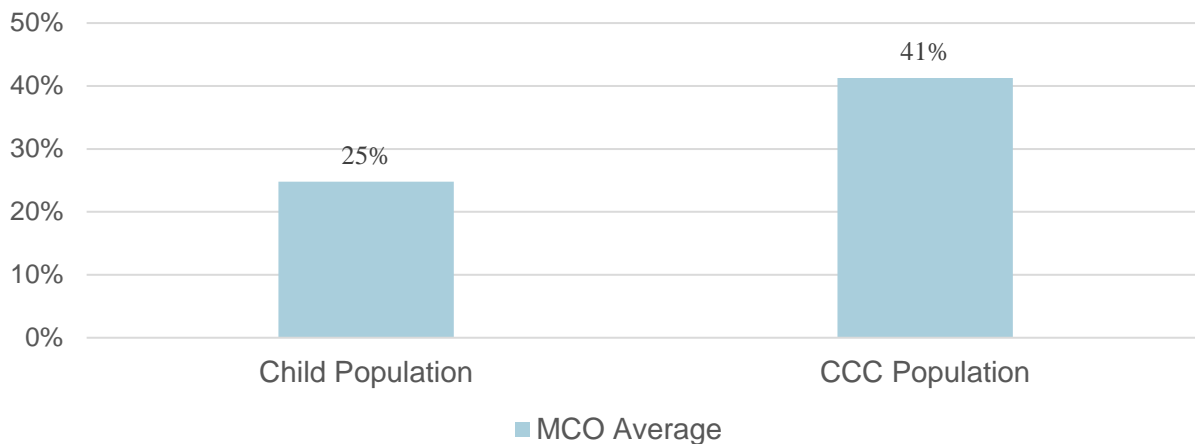
Member responses indicate; an average of 28.5% of members surveyed reported a fall or a problem with balance or walking; and attention to identifying and treating falls and fall risks among healthcare providers aligns with the members' responses with experiencing falls or problems with balance or walking.

**NCQA Approved Additional Questions Care Coordination (Child)**

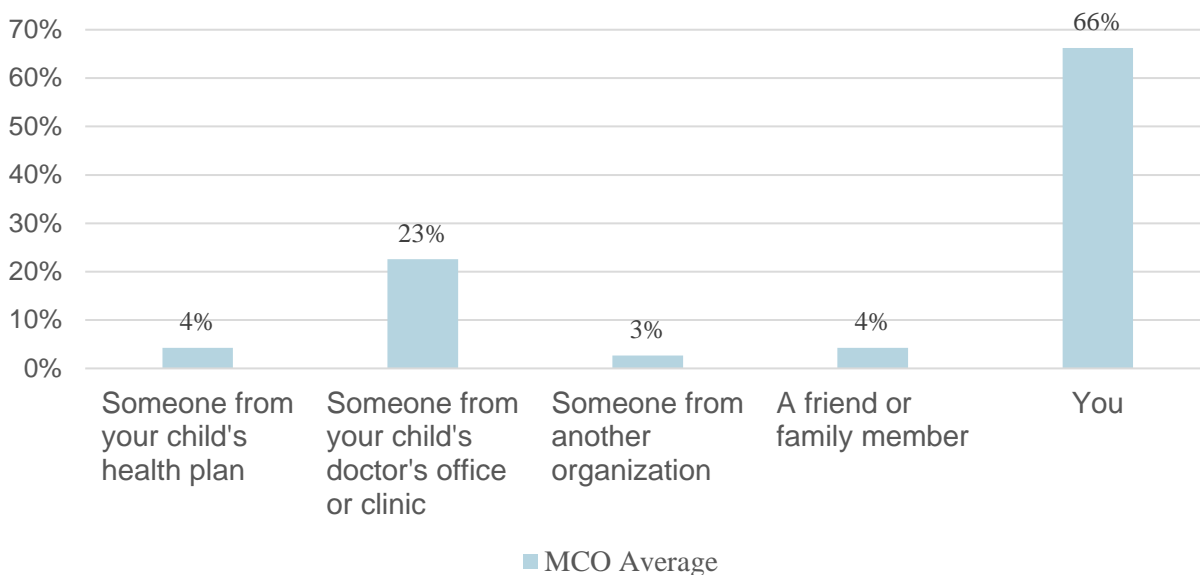
The graph below reflects aggregate percentages of the MCOs for the additional questions for the child survey HSD required the MCOs to include. The results reported are for the child population and the children with chronic conditions populations. There are no national averages reported for these measures.



**In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these doctors or other health providers? (Percent answering "Yes")**

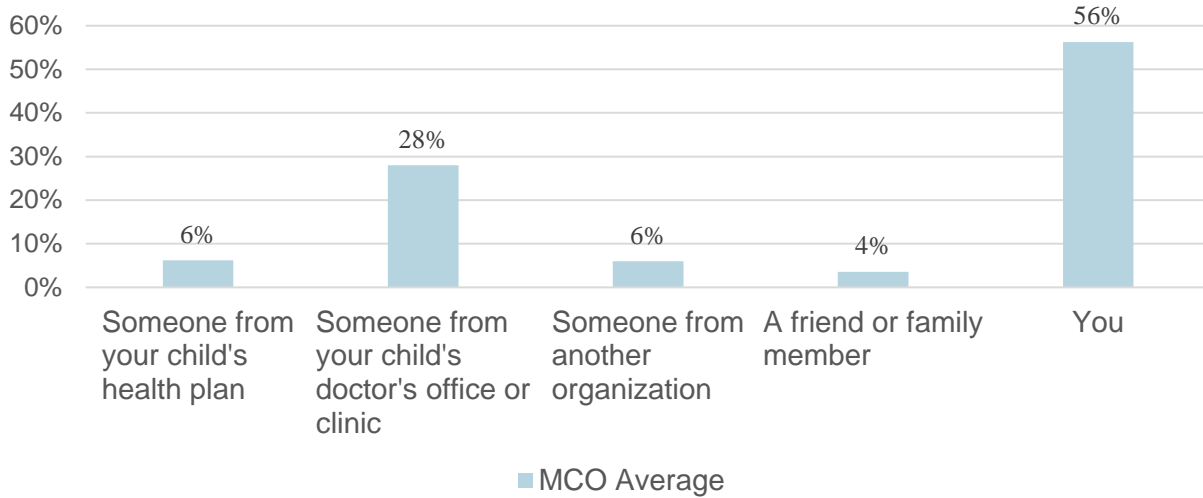


**In the last 6 months, who helped to coordinate your child's care? (Child population)**



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**In the last 6 months, who helped to coordinate your child's care? (CCC population)**



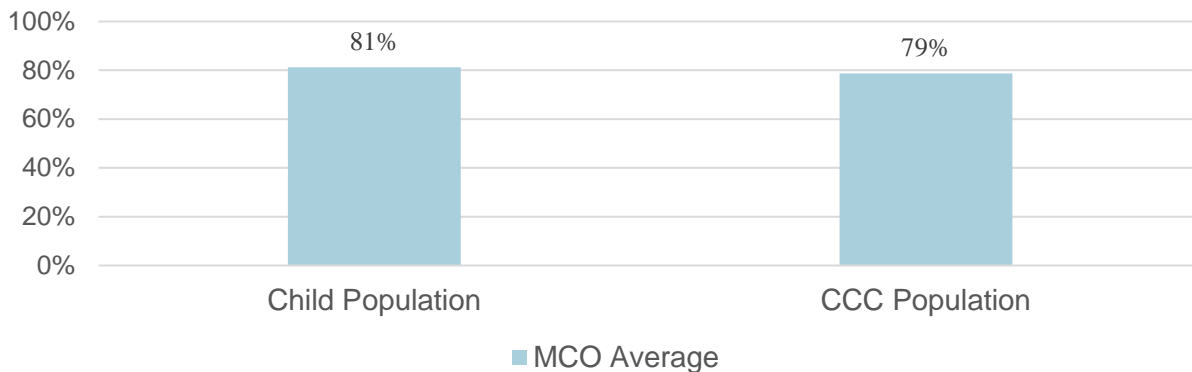
**Conclusion:**

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

**NCQA Approved Additional Questions Member Satisfaction (Child)**

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

**How satisfied are you with the help you got to coordinate your child's care in the last 6 months? (Percent answering "Satisfied or Very Satisfied")**



**Conclusions:**

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

## Utilization

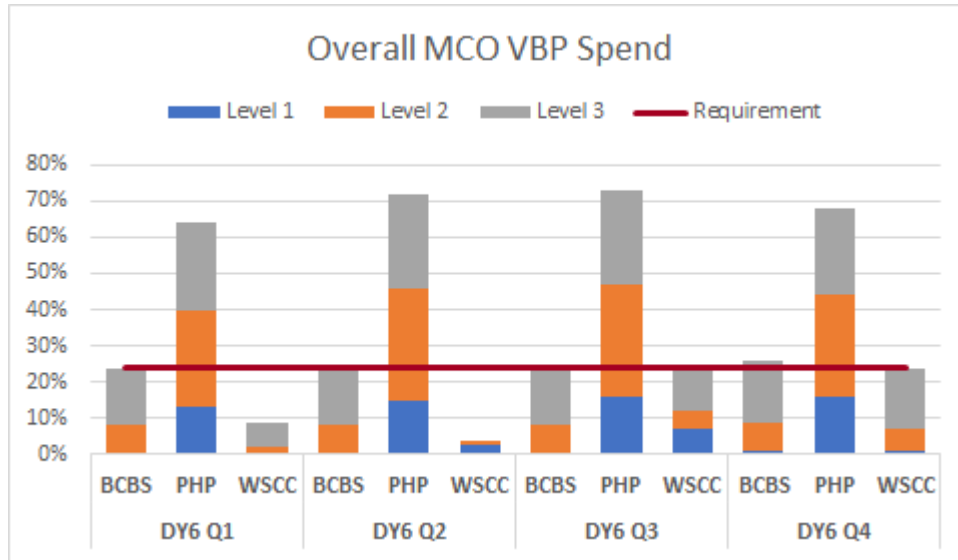
Centennial Care 2.0 key utilization data and cost per unit data by programs is provided for October 2017 through September 2019. Please see Attachment C: Key Utilization/Cost per Unit Statistics by Major Population Group.

## Value Based Purchasing

To support Centennial Care 2.0's value-based purchasing goals, HSD requires the MCOs to implement a Value Based Purchasing program that is based upon improved quality and/or Member healthcare outcomes. To accomplish this the MCO must meet minimum targets for three levels of VBP arrangements. Minimum targets are set to both a required spend as a percentage of paid claims and required contracts with certain provider types. DY6 requirements are as follows:

VBP Level	Level 1	Level 2	Level 3
Required Spend	8%	11%	5%
Required Provider Types	<ul style="list-style-type: none"> <li>Traditional PH Providers with at least 2 Small Providers</li> <li>BH Providers</li> <li>Long-Term Care Providers including Nursing Facilities</li> </ul>	<ul style="list-style-type: none"> <li>Traditional PH Providers with at least 2 Small Providers</li> <li>BH Providers</li> <li>Actively build readiness for Long-Term Care Providers</li> <li>Actively build readiness for Nursing Facilities</li> </ul>	<ul style="list-style-type: none"> <li>Traditional PH Providers</li> <li>Implement a MCO led BH provider level workgroup</li> </ul>

For DY6 Annual, all of the MCOs have already met or exceeded the required VBP spend target of 24%. The requirement of 24% is an overall spend, but MCOs can allocate higher spend in Level 3 to lower spend in Level 2 and Level 1.



### Low Acuity Non-Emergent Care (LANE)

As part of HSD's strategic goal to improve the value and range of services to members, HSD collaborates with MCOs to reduce avoidable ER visits. First, HSD implemented rule changes in 2019 and 2020 resulting in a provider rate increase for outpatient settings, including Evaluation & Management codes, dispensing fees to community-based pharmacies, Long-Term Services and Supports providers, and supportive housing benefits for people with Serious Mental Illness. There also were increases in payment rates to governmental and investor-owned hospitals, as well as hospitals serving a high share of Members who identify as Native American.

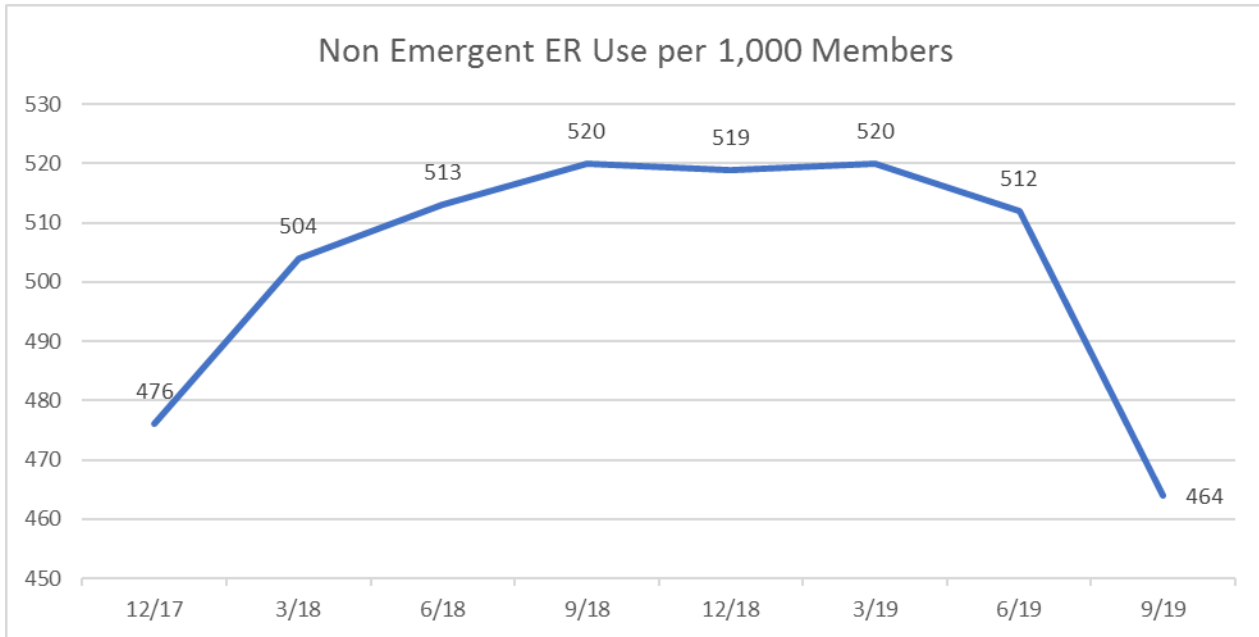
Second, HSD includes requirements in its Centennial Care 2.0 Managed Care Organization Contract that MCOs monitor usage of emergency rooms by their members and evaluate whether lesser acute care treatment options were available at the time services were provided. This results in MCOs identifying high ED-utilizer members by monitoring data such as diagnosis codes and ER visit encounters and taking proactive steps to refer them to providers. Third, MCOs implement member engagement initiatives to assist in identifying member challenges through systemwide activities, including: outreach by care coordinators, peer-support specialists (PSS), CHWs, and community health representatives (CHRs) to decrease inappropriate ER utilization.

Additionally, the Community Paramedicine Program is an additional outreach project supporting this effort. Additionally, because access to primary care is a key factor in reducing nonemergent Emergency Department visits, HSD is also working with graduate medical education (GME) programs to expand existing/establish programming, specifically in the primary care specialties of Family Medicine, General Internal Medicine, General Psychiatry, and General Pediatrics. A GME expansion 5-year strategic plan HSD released in January 2020 estimates that 46 new primary care residents will graduate in NM each year, beginning in 2025; and, the number of primary care GME programs will grow by more than 60% within the next five years. HSD is also supporting primary care GME program development and expansion by awarding up to \$1.535M in funds to programs during FY20.

Finally, HSD implemented a minimum wage adjustment for Personal Care Services (PCS) providers for statewide and regional changes in minimum wage. Further, HSD implemented two (2) new MCO performance measures: 1) Follow-up After Hospitalization for Mental Illness; and, 2) Follow-Up After Emergency Department Visit for Mental Illness. The MCOs will need to increase their individual performance and increase by 1 percentage point above the Regional average; and, failure to meet targets will result in monetary penalties. Finally, WSCC is focusing on primary care, i.e. getting members' primary care services met, as a preventative strategy for preventing and addressing health complications. The WSCC Quality Improvement team is currently working on a robo-dialer campaign for both children and adult members, which will focus on scheduling appointments for members with their PCP. This campaign will run throughout all of 2020. The table below reflects a count per capita, per 1,000 members using the emergency room (ER) for non-emergent care between December of 2017 through September of 2019. Data is reported quarterly based upon a rolling 12-month measurement period and excludes retro membership.

Between March of 2018 and March 2019, ED visits increased by 16 visits per 1,000 members. As a result of the MCO strategies and interventions implemented in 2019, which focused on reducing ED visits for non-emergent care, the count per capita usage per 1,000 members has significantly improved from 2018 to 2019. In comparing visits per 1,000 members, from March of 2019 with 520 visits to September 2019 with 464 visits, the average number of visits to the emergency department for non-emergent care decreased by 56 visits per 1,000 members, which is an 11% improvement. The trend for this measure improved throughout 2019.

**Table 22: Non-Emergent ER Use per 1,000 Members**



January 1, 2019 – December 31, 2023

# 14

## MANAGED CARE REPORTING REQUIREMENTS

### **TRANSITION TO CENTENNIAL CARE 2.0 MCOs**

HSD identified several deficiencies in BCBS' call center performance and underperforming with the Nurse Advice Line (NAL) metrics, but this improved in DY6 Q3 and BCBS met NAL standards in Q4. HSD is closely monitoring BCBS' efforts to remediate these areas of non-compliance, and BCBS has implemented an internal action plan specifically for improving the NAL metrics (see Section 9- MCO Action Plans).

PHP had been underperforming in completing some care coordination activities timely in the first two quarters but improved in Q3 and exceeded timeliness standards by Q4.

### **GEOGRAPHIC ACCESS**

Geographic access performance standards remain the same in DY6 with the requirement that at least 90% of members having access to certain provider types in urban, rural, and frontier geographic areas within a defined distance. Centennial Care 2.0 was live January 1, 2019 with the two legacy MCOs, PHP and BCBS, and one new to Centennial Care MCO, WSCC. Geographical Access is collected and validated on a quarterly basis therefore this section is reflective of January 1, 2019 to September 30, 2019. HSD also notes that report revisions were applied to quarter two (April 1st – June 30, 2019).

## **Physical Health and Hospitals**

Over the course of the 3 quarters legacy MCOs have demonstrated steady access with slight fluctuations in much of the areas and provider categories.

- Legacy MCOs performance in access to general hospitals, PCPs, pharmacies and most specialties in urban, rural and frontier areas were met.
- Geographic access for dermatology, endocrinology, neurology, rheumatology, and urology services as well as access to neurosurgeons were and are anticipated to be limited due to provider shortages in rural and frontier areas.
- HSD has observed that report revisions have resulted in MCO's deeper internal analysis and actions
  - PHP cited system clean up as a change in FQHC-PCP Only category. PHP conducts ongoing market analysis for available providers to inform targeted recruitment.
  - BCBS cited inactive urology providers in an urban area which impacted the access for urban.
- HSD found WSCC to be comparable to legacy MCOs in access for most provider types and improved accuracy in data collection. HSD continues to identify areas of improvement to WSCC for accurate data reporting in accordance with New Mexico's standards guidelines.



**Table 23: Geoaccess PH for DY6 Q4**

<b>DY6 Q4 - GeoAccess PH Q4 Calendar Year 2019 (October 1st -December 31st 2019)</b>									
	Meets Standard						Does Not Meet		
	Urban			Rural			Frontier		
	BCBS	PHP	WSCC	BCBS	PHP	WSCC	BCBS	PHP	WSCC
<b>PH - Standard 1</b>									
PCP including Internal Medicine, General Practice, Family Practice	100.0%	100.0%	100.0%	99.6%	100.0%	100.0%	100.0%	99.9%	100.0%
Pharmacies	100.0%	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%
FQHC - PCP Only	100.0%	100.0%	100.0%	90.8%	89.0%	99.4%	97.3%	86.8%	98.8%
<b>PH - Standard 2</b>									
Cardiology	99.1%	98.8%	98.7%	99.7%	100.0%	99.8%	99.8%	99.9%	99.2%
Certified Nurse Practitioner	99.2%	100.0%	100.0%	99.8%	100.0%	100.0%	99.8%	100.0%	100.0%
Certified Midwives	99.0%	98.8%	93.6%	99.9%	93.9%	93.4%	99.8%	98.4%	98.4%
Dermatology	70.8%	98.8%	98.6%	72.5%	72.2%	86.6%	97.9%	89.0%	98.5%
Dental	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Endocrinology	99.0%	98.7%	98.6%	71.5%	92.3%	74.6%	83.8%	92.9%	82.7%
ENT	99.0%	98.7%	98.6%	91.5%	92.9%	99.9%	92.1%	86.6%	95.8%
FQHC	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Hematology/Oncology	99.0%	98.9%	98.7%	98.8%	91.2%	97.7%	99.0%	97.9%	89.8%
Neurology	99.0%	98.8%	98.6%	91.6%	92.0%	81.6%	89.2%	90.0%	88.6%
Neurosurgeons	99.0%	98.7%	93.4%	37.7%	68.9%	39.0%	68.4%	86.7%	81.0%
OB/Gyn	99.2%	98.9%	98.6%	99.8%	99.6%	99.8%	99.8%	99.9%	99.9%
Orthopedics	99.0%	98.9%	98.6%	99.5%	100.0%	99.8%	99.4%	98.4%	99.8%
Pediatrics	100.0%	98.9%	98.6%	100.0%	100.0%	99.7%	99.8%	99.9%	100.0%
Physician Assistant	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Podiatry	99.0%	98.9%	98.7%	99.8%	99.7%	94.2%	99.8%	99.9%	99.9%
Rheumatology	93.1%	98.8%	85.1%	70.2%	83.1%	65.8%	81.7%	84.9%	72.1%
Surgeons	99.2%	98.9%	98.7%	99.8%	100.0%	100.0%	99.8%	99.9%	99.9%
Urology	80.0%	98.7%	98.6%	87.5%	92.4%	62.4%	94.0%	95.9%	84.0%
<b>LTC - Standard 2</b>									
Personal Care Service Agencies (PCS)	99.2%	100.0%	100.0%	99.3%	99.8%	99.8%	99.8%	100.0%	100.0%
Nursing Facilities	94.6%	92.8%	94.2%	99.7%	99.2%	99.8%	99.8%	99.9%	99.9%
General Hospitals	99.1%	98.8%	98.7%	99.6%	99.5%	99.9%	99.8%	99.9%	99.9%
Transportation	99.1%	100.0%	98.7%	99.6%	100.0%	100.0%	100.0%	100.0%	100.0%

## TRANSPORTATION

Non-emergency medical transportation is a means for MCO to ensure members have timely access to needed services particularly for specialty services and provider shortage areas. All 3 MCOs identify transportation coverage in all counties across New Mexico.

HSD identified a special transportation initiative in DY6 Q1 report. This PHP pilot program is a test run of online scheduling for non-emergency medical transportation for member appointments. All 3 MCOs identify transportation coverage in all counties across New Mexico.

- **New Initiatives:** HSD identified a special transportation initiative developed by PHP in DY6 Q1 report. PHP continues to encourage members to sign up and use the MyRide application for travel arrangements. The application currently has 842 members signed up and using it for routine transportation requests.
- **Grievances:** Consistent with previous reporting Non-Emergency Medical Transportation (NEMT) grievances is the leading category of grievances in the reporting period. Please see Complaints and Grievances for additional information. PHP identified a lack of wheelchair accessible transportation options as a barrier to member access and reported an increase in transportation provider no shows. See section 9 of this report for improvement plans in regards to these barriers and provider issues.

## TELEMEDICINE DELIVERY SYSTEM IMPROVEMENT PERFORMANCE TARGET

The CY19 Telemedicine Delivery System Improvement Performance Target (DSIPT) for Centennial Care 2.0 counts unduplicated members served in rural, frontier, and urban areas of New Mexico.

CY19 serves as the MCO’s baseline year for the Telemedicine DS IPT. This measurement tracks unduplicated members with physical health and behavioral health telemedicine visits telemedicine visiting and focuses on increasing telemedicine availability and utilization along with expanding member education and provider support.

**Table 24: Unduplicated Members Served with Telemedicine**

Total Unduplicated Members Served with Telemedicine (January – December 2019)			
MCO	CY19 Behavioral Health Visits	CY19 Physical Health Visits	CY19 Total Unduplicated Members
BCBS	2,841	3,100	5,198
PHP	4,077	2,001	5,841
WSCC	753	201	935
Total	7,671	5,302	11,974

\* Most telehealth services provided in New Mexico are for behavioral health diagnoses.

Behavioral Health visits represent highest visit utilization at 64% of telemedicine visits in CY19

# 15

## DEMONSTRATION EVALUATION

Evaluation Findings and Design Plan	
DY6 Activities	<p>HSD is awaiting CMS feedback and comment of the DY 1 through DY 4 1115 Demonstration Waiver Evaluation final report which was submitted on April 30, 2019.</p> <p>HSD received feedback and comment regarding the 1115 Demonstration Waiver Evaluation Design Plan on October 21<sup>st</sup>, 2019. HSD reviewed and made the applicable changes to the Evaluation Design Plan for Centennial Care 2.0. The workgroup consisted of; HSD staff from the Medical Assistance Division and Behavioral Health Service Division. HSD contracted with external entities having expertise in developing 1115 Demonstration Waiver Evaluation Design Plans and required CMS monitoring of the Substance Use Disorder 1115 Demonstration Waiver. The workgroup met weekly to review CMS feedback and comments to incorporate the applicable changes to the 1115 Demonstration Waiver Evaluation Design Plan. The workgroup met with internal programs and systems subject matter experts to discuss and identify the data sources, data collection methodologies, and technical specifications for each of the proposed measures to confirm if any changes were needed.</p> <p>HSD has initiated and commenced with drafting the request for proposal (RFP), and procurement process to secure an independent evaluator of the 1115 Demonstration Waiver Renewal, once the Evaluation Design Plan is approved.</p>

# 16

## ENCLOSURES/ATTACHMENTS

Attachment A: October 2017 – September 2019 Statewide Dashboards

Attachment B: Budget Neutrality Monitoring Spreadsheet

Attachment C: Key Utilization/Cost per Unit Statistics by Major Population Group

# 17

## STATE CONTACTS

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Nicole Comeaux Director HSD/Medical Assistance	505-827-7703	<a href="mailto:Nicole.Comeaux@state.nm.us">Nicole.Comeaux@state.nm.us</a>	505-827-3185
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Elisa Walker-Moran Deputy Director HSD/Medical Assistance	(505) 476-6872	<a href="mailto:Elisa.Walker-Moran2@state.nm.us">Elisa.Walker-Moran2@state.nm.us</a>	505-827-3185
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## ADDITIONAL COMMENTS

### MCO INITIATIVES

#### **BCBS Community Paramedicine Remote Monitoring**

The BCBS Community Paramedicine program engages a select group of members in a remote monitoring program which records vital signs including weight, pulse oximetry, heart rate, and blood glucose monitoring, if applicable. This information is monitored by the overseeing community paramedic via Bluetooth and Web Based technology and can be communicated to the member's Primary Care Practitioner (PCP) and/or cardiologist.

These members are receiving approximately 10 visits over a period of 3 to 6 months. The purpose is to monitor treatment adherence and physical assessment to monitor for progress or possible regression.

Though BCBS is awaiting formal analysis, they have reported the following preliminary numbers:

- 18 Members are currently being monitored and graduated from the program
- 73 ED visits pre-referral (6 months cumulative)
- 15 ED visits post-referral (6 months cumulative)
- 34 IP Admissions pre-referral (6 months cumulative)
- 4 IP Admissions post-referral (6 months cumulative)

#### **PHP "THE LAST CALL" INITIATIVE**

The Presbyterian Customers Service Center (PCSC) fully implemented "The Last Call" (TLC) team initiative. This team is dedicated to tracking and resolving root cause issues, handling escalations, and service recovery and process improvement with connectivity to training and quality. This team will assist with many of the current functions that PHP has today but will be a consolidated, one-stop shop for all service recovery and process improvement functions including:

- Supplemental assistance to the TL Escalation queue

- Referred leadership level escalations including tracking, trending, and root cause analysis
- One Call Resolution (OCR) Report review, analysis and coaching
- Post Call Survey service recovery outreach for negative comments and low scores
- Member Survey service recovery outreach from feedback provided on mailed member surveys
- Utilization Management escalation assistance.

In addition, the PCSC implemented “Centennial Chat” which is a new channel of communication creating a chat box for Centennial Care members. The team started training in DY6 Q4 and are now live to respond to member requests for additional information, questions, and direction for utilizing the PHS website.

#### **WSCC Vaccination Reminder Pilot**

WSCC is working with Pfizer to implement the VAKS program. Members will receive a vaccination reminder call and postcard in efforts to increase vaccination rates according to the Bright Futures Guidelines. WSCC will pilot this program and determine if it results in increased timely vaccinations. The results will be provided in a future quarterly report.

#### **WSCC Tobacco Prevention and Cessation Pilot in the School Environment**

WSCC is partnering with the New Mexico Alliance for School Based Health Care and the New Mexico Department of Health to develop a pilot aimed at tobacco prevention and cessation within the SBHC environment. Updates will be provided in future quarterly reports.



## **MEMBER SUCCESS STORIES**

BCBS reports a 33-year-old Quadriplegic member who is a motor vehicle accident survivor which resulted in a traumatic brain injury with an incomplete C5 fracture and a complete C6 fracture. Member lies alone and is wheelchair bound and uses a power chair. The member was having trouble maneuvering his power chair in his apartment due to carpet flooring. With member consent, the BCBS Care Coordinator approached the apartment management company to inquire if the landlord could make modifications to the flooring. The apartment manager agreed to replace the carpet with a firm non-slippery material, with flat transitions from one room to the next. The member indicates that this intervention has promoted his health and provided him with mobility and a sense of safety in his own home.

PHP's Native American Outreach Team recently visited the Whitehorse Lake Senior Center. A Native American member called to acknowledge the team's presentation at their community event. This member shared great reviews of the interactions with community elders and requested that they present again at the next event, indicating the community would like to continue to work with them. Members spoke highly of the knowledge and patience the team demonstrated while providing education on PHP Centennial Care in the Navajo language. Members wanted to thank the team for their hard work and dedication.

A WSCC Program Coordinator (PC) met with a member at a substance abuse treatment facility, who believed he had Hepatitis C. The PC had a conversation with the member about the importance of being tested and receiving treatment if the test was positive. The member was homeless and needed assistance with understanding the process and completing the required forms. The PC helped him complete the forms for intake at the treatment facility, assisted him with selecting a PCP, and obtaining non-emergency transportation. The PC also enrolled the member into a Hep C testing event held at the treatment facility, where the member tested positive. He began treatment, was compliant with the treatment protocol, and completed treatment in December. The member now has a stable living situation, is involved in a literacy program, and has a part-time job.