Quality Strategy
For the
New Mexico State Medicaid
Managed Care Program

Prepared by
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Medical Assistance Division
Quality Bureau

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I. INTRODUCTION

A. Managed Care Goals, Objectives and Overview

Prior to 1997, New Mexico Medicaid clients received their care through a Fee-for-Service (FFS) model. The New Mexico Legislature mandated the Human Services Department, Medical Assistance Division (HSD/MAD) to implement a managed care program and a proposal was submitted under Section 1915(b) of the Social Security Act (the Act) to provide comprehensive medical and social services to the State's Medicaid population. HSD/MAD was awarded approval to operate a statewide managed care program for children and families receiving Medicaid. Eligible members required to participate include those receiving Medical Assistance for Women and Children (MAWC), members receiving Supplemental Security Income, children in foster care or adoption placement, members receiving services under the home and community-based services waiver programs (for non-waiver services only), and other clients deemed eligible by the State.

1. History of New Mexico's Managed Care Programs

New Mexico began the Salud! Program on July 1, 1997. The program was designed to improve quality of care and access to care, and to make cost–effective use of state and federal funds. Approximately 65% of Medicaid-eligible members were mandatory participants in Salud! at that time.

Medicaid safety net programs for children including the State Children's Health Insurance Program (SCHIP, name then changed to CHIP [Children's health Insurance Program]) were combined into one program in New Mexico, known as New Mexikids.

Services to members in both Salud!and New Mexikids are contracted through Managed Care Organizations (MCOs).

The remaining population groups remained in the FFS program, including residents of nursing facilities and Institutional Care Facilities for the Mentally Retarded (ICFs/MR), members eligible for both Medicare and Medicaid (dual eligible's), members enrolled in the Family Planning waiver and the Breast and Cervical Cancer waiver, recipients of the Program of All Inclusive Care for the Elderly (PACE) and Native American members who did not choose to participate in Salud!

A Health Insurance Flexibility and Accountability (HIFA) waiver was approved by the Centers for Medicare & Medicaid Services (CMS) in August 2002. The waiver program

utilizes unspent SCHIP funds to provide basic health benefits for New Mexicans with incomes up to 200 percent of the federal poverty level through an employer based buy-in insurance plan. On March 18, 2005, Governor Bill Richardson signed the State Coverage Insurance Program (SCI) initiative into law. The State Coverage Initiative (SCI) is an innovative insurance product, combining features of Medicaid and a basic commercial plan. Support from the federal government, particularly Medicaid waivers, has provided the flexibility to offer coverage to the individuals most in need throughout the state. The employer premium assistance plan enacted through the SCI program is the foundation on which the state is able to target the population identified as the most likely to be uninsured. This premium assistance program received a Legislative appropriation to cover approximately 10,000 low income working adults at or below 200 percent of the federal poverty limit in a subsidized employer health benefit plan.

The program is currently being administered through the MCOs utilizing federal and state funding plus contributions by employers and employees. Utilizing financing strategies such as group purchasing and tax incentives, employers are assisted in offering health insurance to their uninsured employees and in encouraging those employees to purchase health insurance at reduced cost. New Mexico has focused on building bridges between the public and private sectors with system designs that provide increased access to health care and funding through partnerships between federal, state, and private entities. Elements of this program include health insurance for small businesses, non-profit organizations, the self-employed, and families, children, and pregnant women who are not eligible for Medicaid.

The Coordination of Long Term Services (CoLTS) program was implemented in 2008 and provides managed care for Medicaid-eligible members residing in nursing facilities, participants of the Disabled & Elderly (D&E) waiver, Personal Care Option (PCO) members, members with a qualified brain injury (BI) and dual eligible (Medicare and Medicaid) members. The program is an interagency collaboration between New Mexico Human Services Department, Medical Assistance Division, New Mexico Aging and Long Term Services Department, and New Mexico Department of Health. All acute, preventive and long term care services are provided through contracted managed care organizations. The primary goal of this program is to mitigate the array of problems resulting from the frequent fragmentation of services provided to Medicare and Medicaid dual eligibles.

In 1999, HSD/MAD implemented the PCO program to meet the needs of Medicaid-eligible New Mexico residents who wanted to receive in-home care instead of being institutionalized and who had not yet been placed on a Home and Community-Based Services Waiver.

The Home and Community-Based Services Waiver programs are co-administered with other state agencies and include programs to individuals who require long-term supports and services in order to remain in a family residence, their private home, or in community residences. The programs serve as alternatives to institutional care.

2. The Centennial Care Program

Of the approximately two million citizens in the State, approximately 550,000 people currently receive their health care through the Medicaid program under 12 separate waivers as well as a fee-for-service program; of these, 70% are enrolled in managed care (for physical health). Seven different health plans currently administer this delivery system. These medical services are provided under an umbrella of programs for eligible individuals in more than 40 eligibility categories.

New Mexico is embarking on a new pathway to deliver care to the Medicaid population through an 1115 demonstration waiver. The current waivers (with the exception of the DD [Developmentally Disabled] population and the MF [Medically Fragile] population of the Mi Via program) will be consolidated and combined under one waiver for a new Medicaid program, "Centennial Care." Similarly, the current MCO contracts will be consolidated among those that have demonstrated the ability to deliver improved access, better quality together with cost effectiveness.

Under Centennial Care, enrollees who meet the nursing facility level of care will be eligible for the community benefit. Enrollees who are otherwise Medicaid eligible will be able to access the community benefit without the need for slots. Certain individuals enrolled in Centennial Care who are deaf and blind may access the benefit of community interveners, trained professionals who meet the criteria as determined by the state. The interveners work one-on-one with deaf-blind individuals who are five years and older to provide critical connections to other people and the environment.

3. Structure of the Centennial Care Quality Program

The Quality Bureau is housed within the HSD/MAD and currently consists of 12 employees plus a bureau chief. The bureau is responsible for directing the Division's Quality Program and coordinating existing quality improvement and future health reform initiatives with contracted Medicaid managed care organizations. The bureau is tasked with designing innovative programs focused on improving the health of the population and optimizing quality of care at the patient level including the development of a patient-centered medical home (PCMH) model, health home (HH) model and pay for performance (P4P) for New Mexico's Medicaid members. The bureau directs all aspects of performance measurement for New Mexico Medicaid programs including quality improvement projects, performance measures and performance reporting.

The HSD/MAD Quality Bureau (QB) retains primary responsibility for the management responsibilities of the Quality Strategy, although several internal and external collaborations/partnerships are utilized to address specific initiatives and/or issues.

HSD/MAD/QB oversees the Quality Strategy's overall effectiveness and performance of its Contractors. HSD/MAD/QB is responsible for reporting Quality Strategy activities, findings, and actions to members, Contractors, the Governor, legislators, other stakeholders and CMS.

Federal regulations (42 CFR 431.12) require the State to establish a committee to advise the State Medicaid agency about health and medical care services. The Medicaid Advisory Committee (MAC) serves as an advisory body to the Secretary of the Human Services Department and the Medical Assistance Division Director on policy development and program administration for the health and medical care services provided by the New Mexico Medicaid program. The MAC encourages participation of health professionals, consumers and consumer groups, advocates, public health entities and other stakeholders concerned or involved with the NM Medicaid program. Additionally, quality review committees representing the various populations meet periodically to discuss quality of care issues and performance measure outcomes with the intention of improving health outcomes and safety.

The Interagency Behavioral Health Purchasing Collaborative (The Collaborative) was established in 2004 as a pioneering effort in behavioral health system transformation. The Collaborative is a legal entity with the authority to contract for behavioral health services and to make decisions regarding the administration, direction and management of state-funded behavioral health services and care in New Mexico. The Collaborative is a cabinet-level group representing 15 state agencies and the Governor's office, and it oversees the activities of the Statewide Entity (SE). The SE is responsible for maintaining the New Mexico behavioral health provider network and managing the service delivery system. The primary goal of the Collaborative is to provide a single behavioral health service delivery system in New Mexico which manages behavioral health funds effectively and efficiently, and through which behavioral health consumers are assisted to participate fully in the life of their communities.

The Behavioral Health Collaborative works through a quality workgroup to monitor behavioral health services and quality of care issues for members receiving those services and committees representing the Developmentally Disabled population and long-term care services populations meet periodically to evaluate similar measures and issues.

Building upon current structures established for our Salud! population, long term care population in our CoLTS program and those established for the behavioral health

population through the Collaborative, will be key in establishing this comprehensive service delivery system. Under Centennial Care, enhanced care coordination and community supports services are required of the contracted MCOs. Health Risk Assessments together with Comprehensive Needs Assessments will allow members to be appropriately assigned to care coordination levels, ensuring that care and quality of life are improved and maintained.

4. Goals and Objectives of Centennial Care

The vision of Centennial Care is to:

a. Build a service delivery system that delivers the right amount of care at the right time in the right setting;
b. Educate New Mexico recipients to become more savvy health care consumers;
c. Promote more integrated care;
d. Properly case manage the most at-risk members;
e. Involve Members in their own wellness; and
f. Pay providers for outcomes rather than for processes.

The Centennial Care goals are aligned with those of the National Quality Strategy to:

a. Create a unified, comprehensive service delivery system to assure cost-effective care and to focus on quality over quantity (Better Care);
b. Assure equity in the delivery of high quality preventive, chronic illness, and rehabilitative care and personalized services across the populations and communities served (Better Health/Healthy Communities);
c. Slow the rate of cost growth in program costs over time through better management of care while avoiding cuts (More Affordable Care); and
d. Streamline and modernize the program in preparation for the potential increase in membership of up to 175,000 people beginning January 1, 2014.

A managed healthcare system, such as Centennial Care, allows for the close monitoring of healthcare costs, a strong oversight together with accountability of providers.

Objectives include:

a. Develop a quality framework consistent with, and pertinent to, all Medicaid programs;
b. Continue use of nationally recognized protocols, standards of care and benchmarks;
c. Continue use of a system of rewards for physicians, in collaboration with MCO Contractors, based on clinical best practices and outcomes;
d. Develop collaborative strategies and initiatives with state agencies and other external partners;

e. Build upon prevention efforts and health maintenance/management to improve health status through targeted medical management in the following areas:
   1) Emphasizing disease management;
   2) Planning patient care for the special needs population;
   3) Increasing emphasis on preventative care; and
   4) Identifying and sharing best practices.
f. Assure the effective medical management of at risk and vulnerable populations;
g. Build capacity in rural, frontier and underserved areas; and
h. Collaborate on border health care issues.

To further strengthen our quality improvement efforts, it will be important to coordinate the Quality Strategy with the state-wide strategic plans (including the governor's office, the Department of Health, the New Mexico Health Policy Commission, the American Indian Health Advisory Council, the Office of American Indian Health, the Children, Youth and Families Department, the Family Health Bureau, the New Mexico Health Information Collaborative, the Center for Telehealth at UNM, the Envision NM Quality Improvement Initiative), and to comply with the CMS Quality Strategy.

Summary Table Alignment of Centennial Care Goals with National Quality Strategy:

State Goals	State Objectives
1. Create a unified, comprehensive service delivery system to assure cost-effective care and to focus on quality over quantity.	a. Continue the use of nationally recognized protocols, standards of care and benchmarks.
2. Assure equity in the delivery of high quality preventive, chronic illness, and rehabilitative care and personalized services across the populations and communities served.	a. Develop a quality framework consistent with, and pertinent to, all Medicaid eligibility programs; b. Building upon prevention efforts and health maintenance/management to improve health status through targeted medical management in the following areas: 1) Emphasizing disease management; 2) Planning patient care for the special needs population; 3) Increasing emphasis on preventative care; 4) Reducing disparities in care or serve and; 5) Identifying and sharing best practices.

	c. Building capacity in rural, frontier and underserved areas.
3. Slow the rate of cost growth in costs over time through better management of care while avoiding cuts.	a. Continue the use of a system of rewards for physicians, in collaboration with the MCOs, based on clinical best practices and outcomes; b. Assure the effective medical management of at risk and vulnerable populations.
4. Streamline and modernize the program in preparation for the potential increase in membership of up to 175,000 people beginning January 1, 2014.	a. Develop collaborative strategies and initiatives with state agencies and other external partners; b. Collaborate on border health care issues.

The state will monitor MCO compliance and measure success and/or accomplishments through various mechanisms including: member incentive reports, care coordination reports, care transitions reports, level of care reports, community benefit reports, Patient-Centered Medical Home reports, Health Home reports, utilization management reports, quality improvement reports, disease management reports, member and provider survey results and performance measures.

Summary Table: MCO Reporting Requirements

Objectives	Reports
Care coordination level assignation is evaluated regarding consistency across MCOs; timeliness requirements are met; HRAs and CNAs are completed in a timely fashion; efforts are made to reach Members who refuse assessments.	Care Coordination Reports that include the number of reassessments among the different levels, reasons for reassessment and sources for requests for changes in levels.
Sufficient care coordinators are available for members within different agency types as well as staffing ratios according to geographic location.	Caseload and Staffing Ratio Reports; include analysis of steps taken to accommodate care coordinators serving in rural, frontier and tribal areas.
There is sufficient access to all provider types for Members entering Centennial Care through the expansion population.	Network Adequacy Reports; include steps taken to address adequacy issues.
Appropriate usage of resources	Utilization Management Reports, measuring over -and under-utilization of available resources.
Members with chronic conditions are improving or maintaining their health status.	Disease Management Reports describing initiatives to engage Members to self-manage their chronic conditions. Outcomes include:

	appropriate medication management for people with asthma, increased HbA1c testing for ages 18-75 with types I and II diabetes, retinal eye exam and LDL-C screening and neuropathy testing for kidney disease.
Improve the health of New Mexicans, e.g. by monitoring annual dental visits (ages 2-21), well child visits with a PCP Primary care Provider), children and adolescent access to PCPs, childhood immunizations, use of appropriate medications for people with asthma, breast cancer screening, comprehensive diabetes care, timeliness of prenatal and postpartum care and frequency of ongoing prenatal care.	Compliance reports with benchmarks for HEDIS performance measures.

The State has been successful in developing and implementing systems to support the goals of the program. Systems are in place to collect encounter, provider network, complaint, quality, and satisfaction data.

New Mexico will continue to enhance current performance measures, performance improvement projects and best practices activities across all Medicaid programs to serve as a roadmap for driving member-centered improved outcomes.

Under Centennial Care, the state will focus on eight (8) clinical initiatives specified in the Managed Care contracts and incorporated into each MCO's quality management/quality improvement plans. Those initiatives include:

a. Annual dental visits (Member ages 2-21),
b. Medications for people with asthma,
c. Controlling high blood pressure,
d. Comprehensive diabetes care,
e. Prenatal and postpartum care,
f. Ongoing prenatal care,
g. Antidepressant medication management and
h. Follow-up after hospitalization for mental illness.

These measures are drawn from both the Adult and Child Core Measures sets, which will enable benchmarking. HEDIS methodology will be used and the MCOs must meet the HEDIS National Quality Compass score for these performance measures. These measures span dental, medical and behavioral health care to address whole person care.

B. Development & Review of Quality Strategy

In accordance with 42 CFR 438.200 et seq., the New Mexico Quality Strategy is a coordinated, comprehensive, and pro-active approach to drive quality through creative initiatives, monitoring, assessment and outcome-based performance improvement. The Quality Strategy is designed to ensure that services provided to members meet or exceed established standards for access to care, clinical quality of care and quality of service. It is a comprehensive approach that drives quality through initiatives, monitoring, assessment and outcome-based performance improvement. The strategy is designed to identify and document issues and encourage improvement through incentives, or where necessary, through corrective actions. New Mexico Human Services Department develops and approves the Quality Strategy through the identification of specific goals and objectives. Members, the public and stakeholders provide input and recommendations regarding the content and direction of the Quality Strategy. The MAC reviews the quality strategy and provides input for consideration and incorporation into this document. Public comment and/or input is also solicited from the contracted MCOs, the contracted External Quality Review Organization, Native American Advisory Committee and the general public through the Medicaid website. The document was posted for public comment on the website for approximately 5 weeks.

The Agency retains the ultimate authority for overseeing the Quality Strategy management and direction. The effectiveness of the Quality Strategy will be evaluated annually.

New Mexico's Quality Strategy utilizes a Continuous Quality Improvement (CQI) model. In other words, if a particular activity does not effectively elicit the quality of care information or improvements intended, then alterations are made to that activity or to the Strategy as a whole in order to make it more effective. Compliance with the Strategy is assessed on a regular basis. At a minimum, all aspects of the Strategy are assessed on an annual basis, changes are made and the strategy is updated. When significant changes are made to the strategy, the proposed changes are submitted to CMS for review. The State defines 'significant changes' as changes that materially affect the actual quality of information collected or analyzed. Minor changes in timeframes, reporting dates, or format are not considered significant changes. Thus, the quality assurance activities described represent activities performed as of the date of publication of this strategy and describe the current or most recent example of each task.

New Mexico requires the provision of high quality health care and services whose quality can be demonstrated to its members, the community and its funders. Several quality

initiatives, beyond Member satisfaction, will be implemented in the Centennial Care program. These include care coordination, tracking of performance measures, Member rewards program and extensive MCO reporting and monitoring. The comprehensive needs assessment that is completed by care coordinators identifies the support services necessary for the Member to remain in the community and achieve personal goals. The comprehensive care plan addresses the services that are needed, as identified through the comprehensive needs assessment, to allow the individual to maintain his/her independence. Social, physical and behavioral health considerations all go into the development of the plan of care. Audits will be conducted by the quality bureau to ascertain whether the necessary services were, in fact, provided to the Member.
The degree of success of care integration will be measured through performance measures such as number and percentage of participants with at least one PCP visit, number and percentage of participants who accessed any of the 3 new behavioral health services, well-child visits, number and percentage of participants with follow-up 7 and 30 days after leaving residential treatment center placement or after hospitalization, prenatal and postnatal care and breast and cervical cancer screenings.

The MCOs are providing a Member rewards program. Successful completion of selected healthy behaviors and activities come with incentives that should promote good health, health literacy and continuity of care for all Members. The MCOs will also provide several reports that track their performance on contract requirements such as Member assessments and transitions from nursing facilities to the community and track the number of Members readmitted to a nursing facility after transitioning to the community. These reports, in part, will measure the degree to which services and supports are appropriate for the Members. In addition, HSD/MAD formulates evidenced-based quality initiatives that:

1. Reward quality of care, member safety and member satisfaction outcomes;
2. Support best practices in disease management and preventive health;
3. Provide feedback on quality and outcomes to Contractors and providers, and
4. Provide comparative information to consumers.

Centennial Care will strive to “assure that Medicaid beneficiaries in the program receive the right amount of care, delivered at the right time, cost effectively in the right setting.” Healthcare value is defined as “better health outcomes relative to the cost of achieving them. New Mexico believes that the best way to contain healthcare costs is to drive improvements in quality.

The comprehensive needs assessment that is completed by the care coordinators identifies the support services necessary for the member to remain in the community and achieve personal goals. The comprehensive care plan addresses what is needed to allow the individual his/her

independence. Social, physical and behavioral health considerations all go into the development of the plan of care. Audits will be conducted by the quality bureau to ascertain whether the necessary services were, in fact, provided to the member. The degree of success of care integration will be measured through performance measures such as number and percentage of participants with at least one PCP visit, number and percentage of participants who accessed any of the 3 new behavioral health services, well-child visits, number and percentage of participants with follow-up 7 and 30 days after leaving residential treatment center placement or after hospitalization, prenatal and postnatal care and breast and cervical cancer screenings.

The comprehensive needs assessment also assesses long term care needs including but not limited to: environmental safety, including adaptive needs such as ramps or other mobility assistance, assesses disease management needs including identification of disease state, need for targeted intervention and education and development of appropriate intervention strategies. A social profile is developed, including but not limited to: living arrangements, employment, natural supports, demographics, financial resources, community resources such as senior companion of meals-on-wheels. Cultural information is identified including language and translation needs and utilization of ceremonial or natural healing techniques.

The MCOs are encouraged to use Community Health Workers in the engagement of Members in care coordination activities. The MCOs are required to develop and implement methods for identifying Members who may have the ability and /or desire to transition from an institutional facility to the community. The self-directed community benefit (SDCB) affords Members the opportunity to have choice and control over how SDCB services are provided, who provides the services and how much providers are paid for providing care in accordance with a range of rates per services established by HSD. The MCOs must ensure tht the Member and/or Member's representative fully participates in developing and administering the SDCB and that sufficient supports are made available to assist Members who require assistance.

Support brokers will be available to Members choosing the SDCB; they are responsible for, at a minimum, educating Members on how to use self-directed supports and services and provide information on program changes or updates, review, monitorand document progress of the Member's SDCB services and budget, assist in managing budget expenditures and complete and suibmit budget revisions/requests, assist with employer functions such as recruiting, hiriang and supervising providers, assist with approving/processing job descriptions for direct supports, assit with approving timesheets and purchese orders or invoices for goods,f acilitate resolution of any disputes regarding payment to providers for

sercies rendered, develop the care plan for SDCB services and ensure that the budget amount is included in the comprehensive care plan.

The key traits of high-quality, high value healthcare include:

1. Effectiveness: Concentrates on the appropriateness of care (care that is indicated, given the clinical condition of the patient).
2. Efficient and Coordinated Care over Time: Addresses the underlying variation in resource utilization, overuse, misuse, and duplication in the system and the associated costs. The system should be safe (free from accidental injury) for all patients, in all processes, in all programs, all the time.
3. Patient-Centeredness: Encompasses respect for patients' values, preferences, and expressed needs; coordination and integration of care; information, communication, and education; physical comfort; emotional support (relieving fear and anxiety) and; involvement of family and friends. Timeliness: Addresses access issues with the underlying principle that care be provided in a timely manner (without long waits that are wasteful and often anxiety-provoking).
4. Equity: Ensures that care is based on an individual's needs, not on personal characteristics (such as gender, race, geographical location, or insurance status) that are unrelated to the patient's condition or to the reason for seeking care.
5. Prevention and Early detection: Provides treatment earlier in the causal chain of disease, with resulting slower disease progression and reduced need for long term care.

II. ASSESSMENT

A. Quality and Appropriateness of Care

In New Mexico many factors contribute to health disparities, including access to health care, behavioral choices, genetic predisposition, geographic location, poverty, environmental and occupational conditions, language barriers and social and cultural factors. Native Americans in New Mexico bear a disproportionate share of poor health status and disease. The following are examples of methods to assess quality and appropriateness of care and services to all Medicaid enrollees under the MCO contracts:

1. Data from a variety of sources, including the NM Department of Health, are used to identify the state's health status gap between different population groups and to address areas of focus for Medicaid. An independent consumer supports system will be developed. The system will be available to all Medicaid beneficiaries enrolled in Centennial Care receiving long-term care services and supports. **The Independent Consumer Support System (ICSS) will initially be comprised of numerous existing community resources and supports that have long-standing missions to, and**

reputations for encouraging and supporting individuals to exercise control over their service planning and delivery in order to support personal goals. These community resources and support entities include New Mexico's Centers for Independent Living, the Aging and Disability Resource Center, and the state's Area Agencies on Aging. The ICSS will serve to further these entities' understanding of Centennial Care and the opportunities Centennial Care offers to aged and disabled individuals to further their ability to improve the quality of their lives within their communities. As the ICSS becomes more established, the State expects other, similar resources to become part of the system. The supports system will assist beneficiaries to navigate and access covered health care services and supports. The system will track the volume and nature of beneficiary contacts and the resolution of such contacts at least quarterly. The State will evaluate the impact of the supports system in the demonstration evaluation.

Examples of New Mexico diseases/conditions for which disparities exist include:

a. Late or No Prenatal Care
b. Diabetes Deaths
c. Suicide
d. Drug Induced Deaths

2. Cultural Competency refers to a set of congruent behaviors, attitudes and policies coming together in a system, agency, or among professionals, enabling them to work effectively in cross-cultural situations. Cultural competency involves the integration and transformation of knowledge, information and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques and marketing programs that match an individual's culture and increase the quality and appropriateness of health care and outcomes. Cultural competency is an integral part of assessing appropriateness of care and services to diverse populations.

   MCOs must have an approved Cultural Competency plan in place that identifies race, ethnicity and the primary language of all members, addresses language access, provision of cultural competency training to their staff and an annual assessment of organizational cultural competency. The Medicaid enrollment form and The Health Risk Assessment capture these demographics.

   HSD Native American liaisons hold outreach events for the different Pueblos, providing information about chronic diseases, how to get well and maintain wellness as well as the benefits and services provided by the managed care organizations.

The I/T/U program manager trends claims data supplied by IHS; when particular services (e.g., prenatal) are not utilized sufficiently or appropriately, the program manager contacts the particular agency to determine what the issues are.

3. The Comprehensive Needs Assessment will identify Members with special health care needs.

   In accordance with 42 CFR 438.208(c)(2), the MCO must have a health care professional assess the member when they are identified as potentially having a special health care need (those who have or are at increased risk for a disease, defect or medical condition that may hinder the achievement of normal physical growth and development and who also require health and related services of a type or amount beyond that required by individuals generally). When the assessment confirms the special health care need, the MCO must coordinate the member's health care services with the member's plan of care. The MCO must offer continued coordinated care services to any special health care needs members transferring into the MCO's membership from another MCO. The MCOs must have plans for provision of care for the special needs populations and for provision of medically necessary specialty care, through direct access to specialists.

   The MCOs will provide disease management ("DM") strategies to Members with identified chronic conditions as part of its care coordination processes and activities. The MCOs'DM strategies may include population identification/stratification, collaborative practice models, patient self-management education, evidence-based practice guidelines, process and outcomes measurements and internal quality improvement processes (further explained in section IV).

4. Health Literacy

   The Patient Protection and Affordable care Act, 2012 defines health literacy as "the degree to which an individual has the capacity to obtain, communicate, process and understand health information and services in order to make appropriate health decisions."

5. Heterogeneous Population

   The NM Medicaid population has very diverse needs. Of the major population groups served by Medicaid, a small share of enrollees in each demographic group account for a large share of cost. People with more than $5,000 in annual Medicaid costs make up less than 15 percent of total members, but account for over 75 percent of all spending, due to their complex health needs. As a potential area of reduction in overall Medicaid costs, NM Medicaid will utilize a risk management model in conjunction with more traditional

quality analysis to identify these Members such as encounter and claims data. This model enables the State to focus on specific risk/cost exposures in order to mitigate costs by maximizing efficiency (quality) for the beneficiary. Members that have been identified for this approach include:

a. Low-income, non-disabled children and adults who qualify for federal aid, including low-income elderly or disabled who are covered by both Medicare and Medicaid;
b. Children and adults with disabilities;
c. Low-income, often high risk pregnant women; and
d. High-need, High-cost members.

6. New Mexico has built its quality structure over time by means of its adherence to federal requirements, continual review of applicable national standards and national and/or regional trends, collaboration with partners and its own experiences.

   As required by the Code of Federal Regulations (CFR) 438.202(d), the State assesses how well the managed care program is meeting the objectives outlined in the introduction, through analysis of the quality and appropriateness of care and services delivered to members and the level of contract compliance of MCOs, and through monitoring MCO activities on an on-going and periodic basis.

   Based on the results of assessments of quality and appropriateness of care, the level of contract compliance and MCO monitoring activities, HSD/MAD targets improvement efforts through a number of interventions. In developing interventions for quality improvement, HSD/MAD has utilized the following processes:

   a. Identifying Priority Areas for Improvement - Identification of key clinical and non-clinical areas on which to focus future efforts is done through analysis of state and national trends and in consultation with other entities who are working to improve health care in New Mexico, such as the state legislature, community leaders and advocacy groups, other state agencies and the MCOs.
   b. Establishing Outcome-based Performance Measures - HSD/MAD establishes minimum performance standards, goals and benchmarks based on national standards, whenever possible. The MCOs are expected to achieve the minimum performance standards and are subjected to liquidated damages for failure to meet those standards (the eight performance measures previously discussed). Performance measure reports allow comparison of each MCO’s respective performance with the others and with Medicaid national averages. Each MCO is expected to conduct Performance Improvement Projects (PIPs) in clinical and non-clinical care areas leading to improved health outcomes, efficiency, and member satisfaction. Utilizing financial, population, and disease-specific data and input from the MCO, HSD/MAD selects a focus for

performance improvement to be developed by all MCOs. Additionally, contractors are required to regularly review their data and quality measures to determine MCO-specific Quality Improvement Projects.

c. Identifying, Collecting, Analyzing and Assessing Relevant Data - The MCOs will be required to maintain an information system that collects, analyzes, integrates and reports data as described in 42 CFR 438.242. This system will include encounter data that can be reported in a standardized format. Encounter data requirements will include the following:
    1) Encounter Data (Health Plan Responsibilities) - the health plan will collect, maintain, validate and submit data for services furnished to enrollees as stipulated by the state in its contracts with the health plans.
    2) Encounter Data (State Responsibilities) - the state will develop mechanisms for the collection, reporting and analyses of these, as well as a process to validate that each plan's encounter data are timely, complete and accurate. The state will take appropriate actions to identify and correct deficiencies identified in the collection of encounter data. The state will have contractual provisions in place to impose financial penalties if accurate data are not submitted in a timely fashion. Additionally, the state will contract with its EQRO to validate encounter data through medical record review.
    3) Encounter Data Validation Study for New Capitated Managed Care Plans - If the state contracts with new managed care organizations, the state will conduct a validation study 18 months after the effective date of the contract to determine completeness and accuracy of encounter data. The initial study will include validation through a sample of medical records of demonstration enrollees.
    4) Submission of Encounter Data to CMS - The state will submit encounter data to the Medicaid Statistical Information System (MSIS) and when required to the T-MSIS (Transformed MSIS) as is consistent with federal law. The state will assure that encounter data maintained at managed care organizations can be linked with eligibility files maintained by the state.

Methods utilized to assess relevant data may vary given the project. Data sources can include computer-based information with targeted data mining; data maintained by other state agencies; data self-reported by MCOs; national research data bases and reports; member records; satisfaction surveys; service plans; and state agency surveys. As an example: One method to monitor appropriate access to primary care is to look at hospital utilization and Ambulatory Care Sensitive Conditions (ACSC). Certain types of hospital admissions are classified as ACSC, which may be chronic or acute conditions. This categorization reflects that, in general, more adequate outpatient health care for these conditions results in reduced hospitalizations. ACSC chronic conditions include, but are not limited to, asthma, congestive heart failure, hypertension and diabetes.

ACSC acute conditions include conditions such as tuberculosis, pneumonia, and immunization- preventable diseases, like Pertussis. High rates of ACSC hospitalizations may be related to economic hardship or geographic access to primary health care services, but can also reflect the overall health care system performance in a region. HSD/MAD may also use its contracted External Quality Review Organization (EQRO) to assist with some or all phases of a specific study or project.

This strategy defines monitoring and reporting measures for all managed care organizations with the following six goals:

1) Assessing whether state, federal, and contract requirements are met;
2) Providing feedback to health plans;
3) Identifying potential best practices and potential concerns;
4) Improving the care delivered to consumers;
5) Demonstrating value-driven purchasing; and
6) Quantifiable, performance-driven objectives.

B. National Performance Measures

On 12/21/2012, the NM Human Services Department was awarded a grant to implement the Predictive Risk Intelligence System (PRISM II), a groundbreaking tool supporting quality of care for the most at-risk Medicaid recipients. Development of PRISM II will result in the collection, linkage and reporting of physical and mental health measures, with the ability to stratify by demographic characteristics and health disparity analyses. This technology will allow for the collection of data for the CMS core performance measures for adults and children in Medicaid/CHIP. It will enable New Mexico to collect data across multiple systems as changes in the Medicaid program are implemented through managed care, not just from managed care plan summaries of HEDIS results, but across plans. PRISM II will allow an infrastructure capable of reporting, analyzing and using data for monitoring and improving access and quality, with a focus on dual eligible populations as well as the ability to conduct related Medicaid performance improvement projects focusing on disease management for diabetes and screening/management for clinical depression. Because this technology is new, it is anticipated that within 6 months of development the State will have a better knowledge of which adult core measures will be analyzed first, with expansion to all adult core measures as well as childhood core measures. Benchmarks will be set up and evaluated across the MCOs.

C. Monitoring and Compliance

HSD/MAD utilizes several mechanisms to monitor member health care services provided by contracted MCOs or individual providers. The State evaluation plan will address quality of care

through performance measures such as EPSDT screening ratio (CMS 416 report), monitoring for patients on persistent medications (HEDIS), neonatal mortality rate(MMIS and encounter data), number and percentage of pre-term births (MMIS and encounter data), low birth weight rate (MMIS and encounter data), medication management for people with asthma (HEDIS), use of appropriate medications for people with asthma (HEDIS), adult BMI assessment (HEDIS), weight assessment for children/adolescents (HEDIS), comprehensive diabetes care (HEDIS), ambulatory care sensitive (ACS)admission rates (MMIS and encounter data), number and percentage of avoidable emergency department (ED) visits that are potentially avoidable (using an algorithm developed by New York University Center for Health and Public Service Research)(MMIS and encounter data), drug overdose mortality rate (MMIS and encounter data), inpatient admissions to psychiatric hospitals and RTCs (MMIS and encounter data), percentage of nursing facility residents with pressure ulcers that are new or worsened (MDS).

Patient safety will be addressed through the comprehensive needs assessment that includes identification of environmental hazards in the home that require attention in the comprehensive care plan; nursing facility resident falls will also be monitored (MDS). The evaluation plan will measures for access to care such as access to preventive/ambulatory health services (HEDIS), utilization of mental health services (HEDIS), number and percentage of people with annual dental visits (HEDIS), enrollment in Centennial Care as a percentage of state population (MMIS and current population survey), number and percentage of participants who accessed a physical health, behavioral health and LTSS service (MMIS and encounter data), number and percentage of unduplicated participants with at least one PCP visit (MMIS and encounter data), percentage of PCP panel slots open (MCO PCP report), number/ratio of participating providers to enrollees (MCO network adequacy, PCP and geographic access reports.

Regarding accountability, failure of the MCOs (or subcontractors) to comply with the obligations specified in their contracts may result, at HSD's discretion, remedies, sanctions and damages such as issuing a notice of deficiency, identifying the deficiency(ies) and follow-up recommendations/requirements in the form of a corrective action plan (CAP) or an HSD directed corrective action plan (DCAP). If the MCO does not effectively implement the CAP/DCAP within the timeframe specified in the CAP/DCAP, HSD may impose additional remedies or sanctions. Intermediate sanctions may include suspension of auto-assignment of members who have not selected an MCO, disenrollment of Members by HSD, rescission of marketing consent and suspension of the MCO's marketing efforts, actual damages incurred by HSD and/or Members resulting from the MCO's nonperformance of obligations under its contract.

Cost-effectiveness will be measured through the performance measures in the evaluation plan: inpatient services exceeding $50,000 (this threshold may be adjusted after reviewing encounter data)(encounter payment data), use of diagnostic imaging (encounter payment data), ED use(encounter payment data), all cause readmissions (MCO facilities readmission report), inpatient services for mental health/substance use (encounter payment data).

Regarding efficiency, the State is implementing new processes and technologies for program management, reporting and delivery system reform. Evaluation performance measures include: number and percentage of providers using electronic health records/participating in the Health Information Exchange (MCO performance improvement project report), use of different delivery

models, such as number of health home participants (TBD once implemented), percentage of claims paid accurately (MCO claim payment accuracy reports), number and percentage of visits in compliance with electronic visit verification system requirement (MCO electronic visit verification report), adoption of electronic case management/care coordination system by MCOs (MCO care coordination report) and amount of federal waiver reporting and oversight-number of reports and staff time (HSD staff reports).

With respect to payment methodologies to reward performance, the MCO contract includes a description of a delivery system improvement fund. The MCO must withhold one and a half percent, net of premium taxes, NM Medical Insurance Pool assessments and adjustments, of HSD's capitation payments. The fund will be released to the MCO based on achieving the following measures related to value of healthcare services provided (there is an additional measure for increasing utilization of HIT and HIE): a minimum of a fifteen percent increase in telehealth "office" visits with specialists, including behavioral health providers, for members in rural and frontier areas. At least five percent of the increase must be visits with behavioral health providers; a minimum of five percent of the MCOs' Members will be served by patient-centered medical homes and a minimum of a ten percent reduction in non-emergent use of the emergency room. In the near future, the MCOs will develop payment reform programs to address the cost effectiveness.

Areas of focus include measurement of improvement both qualitatively and quantitatively in:

1. Quality of care;
2. Patient safety;
3. Access to care;
4. Accountability;
5. Cost-effectiveness;
6. Efficiency;
7. Payment methodologies to reward performance, measured by the “value” of healthcare services provided; and
8. Implementation and utilization of health information technologies. *
   *These areas of focus are addressed throughout the document.

Quality improvement activities are identified and chosen to improve the quality and safety of clinical care processes as well as the quality of services provided by the MCOs. HSD/MAD has used the following incentives and monitoring activities to measure progress toward achieving established targets/goals and benchmarks:

1. HSD/MAD negotiated contracts with the MCOs that include all the federally required quality elements as well as state mandated quality and performance improvement requirements. The contracts also require the MCOs to develop a planned process with submission to HSD/MAD that includes data collection, evaluation, and analysis to determine interventions and/or activities that are projected to have a positive effect on

health care outcomes. HSD/MAD monitors all contract requirements and mandates accordingly;

2. HSD/MAD monitors and evaluates access to care, organizational structure and operations, clinical and non-clinical quality measurement and performance improvement outcomes through:

    a. Annual operational and financial reviews;
    b. Review and analysis of periodic reports; and
    c. Review and analysis of program-specific Performance Measures and Performance Improvement Projects.

    Appropriate action is taken based on the results.

3. The MCO contract specifies liquidated damages for failure to perform specific responsibilities or requirements as described in the contract. The MCO's failure to meet targets for the performance measures described in contract result in a liquidated damage based on 2% of the total capitation paid to the MCO the contract year, divided by the number of performance measures specified in the contract.

4. The MCOs are mandated to implement recommended practice guidelines, practice parameters, consensus statements and specific criteria for the provision of acute and chronic physical and behavioral health care services available to network providers.

5. Performance Improvement Projects (PIPs) are a planned process of data gathering, evaluation, and analysis to determine interventions or activities that are anticipated to have a positive outcome. PIPs are designed to improve the quality of care and service delivery and involve:

    a. Identifying areas for improvement;
    b. Gathering baseline data from administrative data and other sources;
    c. Designing and implementing interventions;
    d. Measuring the impact of the intervention; and
    e. Maintaining/sustaining that improvement.

    HSD/MAD requires its MCOs to submit an annual Quality Management Plan and PIP proposal. The HSD/MAD Quality Strategy has been developed to include an annual evaluation of completed and continuing quality improvement activities that address the quality and safety of clinical care and the quality of services, determination of any demonstrated improvements in quality of care and services and assessment of the overall effectiveness of the strategy.

6. PIP proposals must include identification of the individual(s) responsible for addressing the identified issue, a root cause analysis, identification of interventions that will be implemented and a proposed timeline. The selected PIPs are reviewed annually by the EQRO.

7. HSD/MAD posts aggregate results of performance measures on the MAD Website, http://www.hsd.state.nm.us/mad/; this includes contractor's individual performance measure rates, MCO plan comparison and plan comparison with national standards and/or benchmarks.

   Health care quality problems are not always captured by measurement efforts designed for the general population, therefore, a search for different quality measures to assess the care provided to vulnerable populations is critical in order to best assess risks and analyze quality. A combination of general and targeted measures is most likely to help identify the highest priority quality issues for our target populations and our program goals.

8. HSD/MAD Performance Measures are selected using data to identify the strengths and opportunities for improvement in health care. Guiding principles:

   a. Seek usefulness, not perfection, in measurement;
   b. Use a balanced set of measures based on national standards when possible;
   c. Keep measurement simple; and
   d. Use qualitative and quantitative data.

9. Measures are selected based on nationally endorsed measures, ones that enable the state to monitor performance relative to stated goals and ones that are most applicable to priority populations. Current performance measurements include:

   a. PM #1 – Annual Dental Visit: The percentage of enrolled Members ages two (2) to twenty-one (21) years, who had at least one (1) dental visit during the measurement year.
   b. PM #2 – Use of Appropriate Medications for People with Asthma: The percentage of Members ages five (5) through eleven (11) years and ages twelve (12) to eighteen (18) years, who are identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.
   c. PM #3 – Controlling High Blood Pressure: The number of Members, ages eighteen (18) to eighty-five (85) years, who had a diagnosis of hypertension with blood pressure control (<140/90) in the most recent blood pressure reading in medical chart in the measurement year: (i) the lowest systolic and lowest diastolic reading will be used if there are several blood pressure recorded on the same date the and (ii) Member reported blood pressure readings are not acceptable.

d. PM #4 – Comprehensive Diabetes Care (HbA1c Testing): The percentage of Members ages eighteen (18) through seventy-five (75) years with diabetes (Type 1 or Type 2) who had each of the following during the measurement year: an HbA1c Test; HbA1c Poor Control than 9.0%); a retinal eye exam; LDL-C screening; and a nephropathy screening test for kidney disease.cv
e. PM #5 – Timeliness of Prenatal and Postpartum Care: The percentage of Member deliveries that received a prenatal care visit as a Member of the CONTRACTOR's MCO in the first trimester or within forty-two (42) Calendar Days of enrollment in the CONTRACTOR's MCO; the percentage of Member deliveries that had a postpartum visit on or between twenty-one (21) and fifty-six (56) Calendar Days after delivery.
f. PM #6 – Frequency of On-Going Prenatal Care: The percentage of Member deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received greater than eighty-one percent (81%) of expected prenatal visits.
g. PM #7 – Antidepressant Medication Management: The number of Members age eighteen (18) years and older as of April 30 of the measurement year who were diagnosed with a new episode of major depression during the intake period and received at least eight-four (84) Calendar Days (12 weeks) of continuous treatment with antidepressant medication or received at least one-hundred eighty (180) Calendar Days (6 months) of continuous treatment with an antidepressant medication.
h. PM #8 – Follow-up after Hospitalization for Mental Illness: Discharges for Members six (6) years of age and older who were hospitalized for treatment of selected mental health disorders with follow-up with a mental health practitioner within seven (7) Calendar Days or thirty (30) Calendar Days after discharge. Include outpatient visits, intensive outpatient Encounters, or partial hospitalizations that occur on the date of discharge.
i. TM#1- # of Medicaid Recipients > 65 yrs. of age who had a fall or had problems with balance/walking in the past 12 months; who were seen by a practitioner in the past 12 months; and who received fall risk intervention from their current practitioner.

10. HSD/MAD uses the Healthcare Effectiveness Data and Information Set (HEDIS) to develop, collect and report data for most Performance Measures (PMs). The results reported are indicators of members' access to and receipt of recommended clinical care. Other measures include results from the CAHPS survey and hospital readmission rates. The measures provide trend information, which may offer guidance in designing focused interventions for quality improvement by the MCOs. Audited HEDIS data will not be available until 2016. NCQA has approve the use of HEDIS-Like measures for the interim period.

11. The New Mexico Legislative Finance Committee outlines performance measures to benchmark success or delineate challenges in meeting intended outcomes. These targets

reflect current priorities and areas of concern for the population covered by the Medicaid MCO contracts.

D. External Quality Review Organization (EQRO)

HSD/MAD monitors contractor compliance with federal and state regulations and contract requirements through reviews and audits conducted by HSD/MAD staff and/or the state contracted External Quality Review Organization (EQRO). An independent EQRO annually evaluates the Federal and State regulatory requirements and performance standards as they apply to MCOs in accordance with 42 CFR 438 Subpart E. The EQRO and/or HSD/MAD:

1. Reviews progress accomplished toward implementing the recommendations made during the previous review;
2. Reviews outcomes of interventions for PMs and PIPs;
3. Reviews records of appeals for timeliness and appropriateness;
4. Determines contractor compliance with its policies and procedures, and evaluates the effectiveness of those policies and procedures;
5. Provides technical assistance and identifies areas in which improvements can be made, as well as identifying areas of noteworthy performance and accomplishment;
6. Conducts interviews or group conferences with members of the contractor's administrative staff; and
7. Examines records, books, reports, and information systems of the MCO, as necessary.

HSD/MAD mandated EQRO Activities use CMS Protocols established under 42 CFR § 438. The activities include:

1. Review to assess MCO compliance with HSD's criteria for determining nursing facility level of care;
2. Independent Assessment/EQR of Each Health Plan; the Independent Assessment (IA) is an in-depth analysis of quantitative and qualitative information obtained regarding the Behavioral Health, Physical Health and the Coordination of Long Term Services programs in general. The IA focuses on access to care, quality of care and cost-effectiveness of the programs. The IA is done every 3 years.
3. A Detailed Technical Report including the CMS mandatory regulatory requirements outlined in the EQRO toolkit. The protocols will align with the CMS core quality measures and national initiatives (including CHIP);
4. Validation of performance improvement projects;
5. Validation of MCO performance measures reported;

6. Review to determine MCO compliance with HSD's managed care regulations and quality standards; and
7. Validation of encounter data.

HSD/MAD has contracted with *HealthInsight* New Mexico since July 1, 2005 to provide EQRO services. *HealthInsight* New Mexico continues to provide oversight of the MCOs as directed by HSD/MAD to ensure compliance with all mandated activities including the state's operational standards, identified performance measures and performance improvement projects (PIPs).

III. STATE STANDARDS

A. Access Standards

1. Availability of Services

The MCOs must have an adequate provider network in order to ensure access to quality care and an ability to demonstrate that the network is sufficient to meet the health care needs of all Members. The MCOs must have written policies and procedures that describe how access to services will be available including prior authorization and referral requirements for medical and surgical treatments, emergency room services, behavioral health and long term care services. These policies and procedures must be approved by HSD and be available upon request to HSD, providers and Members.

Federal law prohibits restricting access to family planning services for Medicaid recipients. The MCOs must implement written policies and procedures, previously approved by HSD, that define how Members are educated about their right to family planning services, freedom of choice (including access to non-contract providers) and methods for accessing family planning services. The family planning policy will ensure that Members of the appropriate age of both sexes who seek family planning services be provided with counseling pertaining to the following: HIV and other sexually transmitted diseases, risk reduction practices and birth control pills and devices.

Each female member will also have the right to self-refer to a contract provider women's health specialist for covered services necessary to provide women's routine and preventive health care services.

Enrollees with special health care needs (those who have or are at increased risk for a disease, defect or medical condition that may hinder the achievement of normal physical growth and development and who also require health and related services of a type or amount beyond that required by individuals generally) must have direct access to a

specialist, as appropriate for the individual's health care condition, as specified in 42 CFR 438.208(c)(4).

Each MCO must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area and offers an adequate range of preventive, primary, pharmacy, behavioral health, specialty, and HCBS services for the anticipated number of enrollees in the service area. These are reported quarterly to HSD through required MCO reports.

Members or their Representatives have the right to seek a second opinion from a qualified health care professional within the provider network, or the MCO will arrange for the Member to obtain a second opinion outside the network, at no cost to the Member. A second opinion may be requested, when the Member or the Member's Representative needs additional information regarding recommended treatment or believes the provider is not authorizing requested care.

If the MCO is unable to provide covered services to a particular Member using contract providers, the MCO must adequately and timely cover these services for that Member using non-contracted providers, for as long as the MCO's provider network is unable to provide them. At such time that the required services become available within the MCO's network and the Member can be safely transferred, the MCO may transfer the Member to an appropriate contracted provider according to a transition of care plan developed specifically for the Member.

The MCO must contract with a sufficient number of specialists with the necessary range of expertise to ensure that the needs of the Members are met within the MCO's provider networks. The MCOs will also have a system to refer Members to non-contract providers if providers with the necessary qualifications or certifications do not participate in the network. Out-of-network providers must coordinate with the MCOs with respect to payment. The MCO must ensure that cost to the Member is no greater than it would be if the services were furnished within the network.

The MCO must have written policies and procedures for the credentialing and re-credentialing processes, including the ability to apply online. The mechanism used for credentialing/re-credentialing will be documented by the MCO. This documentation will include defining the scope of providers covered as well as the criteria and primary source of verification of the information used to meet these criteria as well as the process used to make non-discriminatory decisions. The credentialing/re-credentialing process will:

a. Meet NCQA standards (behavioral health agencies exempted), State and Federal regulations;
b. Use one standard application form developed in collaboration with the MCOs;
c. Designate a credentialing committee or other peer review body to make recommendations regarding credentialing/re-credentialing issues;
d. Complete the credentialing process within 45 calendar days from receipt of the completed application with all required primary source documentation;
e. Include required disclosures (e.g. ownership, criminal conviction information);
f. Screen all providers against the "List of Excluded Individuals/Entities or Medicare Exclusion Databases monthly; and
g. Have written policies and procedures to verify provider licenses and certifications to perform services outlined in their agreements.

The MCO will establish mechanisms, such as notices or training materials, to ensure that contract providers comply with the timely access requirements, monitor such compliance regularly and take corrective action if there is a failure to comply.

The MCO will also ensure that contract providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees.

Services will be available (24) hours, seven (7) days a week, when medically necessary.

The MCO is responsible for:

a. Monitoring all provider (contracted/subcontracted providers) activities to ensure compliance with the MCO's and the State's policies;
b. Establishing mechanisms to ensure that contract providers comply with the timely access requirements, monitor contract providers regularly to determine compliance and take corrective action if there is a failure to comply;
c. Educating Primary Care Physicians (PCPs) about special populations and their service needs; and
d. Ensuring that PCPs successfully identify and refer Members to specialty providers as medically necessary.

The MCO must develop written policies and procedures and implement a *Cultural Competency/Sensitivity Plan (submitted to HSD for approval)*, through which the MCO ensures that it provides culturally competent services to its Members, both directly and through its contract providers and subcontractors. The Plan will include a description of how it ensures that covered services provided will be culturally competent and provisions

for monitoring and evaluating disparities in membership (who is enrolled), especially as related to Native Americans.

The MCO will participate in HSD's efforts to promote the delivery of covered services in a culturally competent manner to all Members, including Members who have: a hearing impairment, Limited English Proficiency (LEP), a speech or language disorder, physical disabilities, developmental disabilities, differential abilities and diverse cultural and ethnic backgrounds (refer to section II, page 10 regarding the cultural competency plan).

The MCO will also:

a. Target cultural competence training to Member services staff and contract providers, including PCPs, care coordinators, case managers, home health care MCO staff and ensure that staff at all levels receive ongoing education and training in culturally and linguistically appropriate service delivery;
b. Develop and implement a plan for interpretive services and written materials to meet the needs of Members and their decision-makers whose primary language is not English, using qualified medical interpreters (both sign and spoken languages), and make available easily understood Member-oriented materials and post signage in the languages of the commonly encountered group and/or groups represented in the service area;
c. Identify community advocates and agencies that could assist LEP and/or that provide other culturally competent services, which include methods of outreach and referral;
d. Incorporate cultural competence into utilization management, quality improvement and planning for the course of treatment;
e. Identify and employ resources and interventions for high-risk health conditions found in certain cultural groups;
f. Recruit and train a diverse staff and leadership that are representative of the demographic characteristics of the State;
g. Ensure that new Member assessment forms contain questions related to primary language preference and cultural expectations and that information received is maintained in the Member's file;
h. Conduct initial and annual organizational self-assessments of culturally and linguistically competent-related activities and integrate cultural and linguistic competence-related measures into its internal audits, performance improvement programs, member satisfaction surveys and outcomes-based evaluations; and
i. Hold semi-annual meetings with Native American representatives from around the State of New Mexico that represent geographic and Member diversity.

2. Assurance of Adequate Capacity and Services

The MCO will establish and maintain a comprehensive network of providers capable of serving all its Members.

Distance Requirements for PCPs and Pharmacies:

a. Ninety percent (90%) of Urban Members will travel no farther than thirty (30) miles;
b. Ninety percent (90%) of Rural Members will travel no farther than forty-five (45) miles; and
c. Ninety percent (90%) of Frontier Members will travel no farther than sixty (60) miles.

The MCO will contract with a sufficient number of specialists with the applicable range of expertise to ensure that the needs of the Members are met within the MCO's provider network. The MCO will also have a system to refer Members to non-contract providers if providers with the necessary qualifications or certifications do not participate in the network.

With the exception of Dual Eligibles, the MCO will ensure that each Member is assigned a PCP. For Dual Eligibles, the MCO will be responsible for coordinating the primary, acute, Behavioral Health and Long-Term Care services with the Member's Medicare PCP. For all other Members, the PCP shall be a medical or Behavioral Health provider participating with the MCO who has the responsibility for supervising, coordinating, and providing primary health care to Members, initiating referrals for specialist care, and maintaining the continuity of the Member's care.

3. Coordination and Continuity of Care

The MCO will design and implement care coordination that includes the following steps:

a. Perform Health Risk Assessments and determine initial placement in care coordination level;
b. Place members in care coordination levels in accordance with standards indicated in the MCO contract;
c. Perform comprehensive needs assessments for those Members who meet the conditions specified in the MCO contract.

If a member enrolls in one MCO from another MCO, the new MCO will obtain relevant information and data from the transferring MCO in order to facilitate continuity of care; contact the Member's previous MCO and request "transition of care data". If the previous MCO is contacted by another MCO requesting "transition of care data" for a Member who has transferred from that MCO to the requesting MCO, that MCO will provide such data.

In coordinating Members' care, the MCO will ensure that each Member's privacy is protected consistent with the State and federal confidentiality requirements, including those listed in 45 C.F.R Parts 160 and 164 (HIPAA).

The MCO will conduct a Health Risk Assessment (HRA), per HSD guidelines and processes, for the following purposes:

a. Introducing the MCO to the Member;
b. Obtaining basic health and demographic information about the Member;
c. Assisting the MCO in determining the level of care coordination needed by the Member; and
d. Determining the need for a nursing facility level of care (NF LOC) assessment, and reassessment determination periods based on uniform guidelines in the NM NF LOC instructions and Criteria (365 days for HCBS, initial Low NF 60day, LNF continuation 365 days, initial High NF 30days, and for continuation of High NF 90 day period).

The MCO will perform an in-person comprehensive needs assessment on all Members identified for care coordination levels 2 or 3. Members assigned to care coordination level level 1 will not receive a comprehensive needs assessment and will not be assigned an individual care coordinator; however, they will be monitored by the care coordination unit by having an HRA performed annually and claims and utilization data review at least quarterly to determine if a particular Member requires a comprehensive needs assessment with a potentially higher level of care coordination. Members identified for care coordination level 2 will have one of the following characteristics:

a. Co-morbid health conditions;
b. Frequent emergency room use (as defined by the MCO);
c. A mental health or substance abuse condition causing moderate functional impairment;
d. Requiring assistance with two (2) or more ADLs or IADLs living in the community at low risk;
e. Mild cognitive deficits requiring prompting or cues; and/or
f. Poly-pharmaceutical use.

The MCO will assign to each Member in care coordination level 2 care coordination a specific care coordinator. Care coordinators for Members in care coordination level 2 will provide and/or arrange for the following care coordination services:

a. Assistance in the development and implementation of a person-centered plan;
b. Monitoring of the care plan and working with the individual to determine if the care plan is meeting the Member's identified needs;
c. Assessment of need for assignment to a health home;
d. Targeted health education, including disease management, based on the Member's individual diagnosis (as determined by the comprehensive needs assessment);
e. Annual comprehensive needs assessment to determine if the care plan is appropriate and if a higher or lower level of care coordination is needed;
f. Semi-annual in-person visits with the Member; and
g. Quarterly telephone contact with the Member.

Based on the comprehensive needs assessment, the MCO will include in care coordination level 3, at a minimum, Members:

a. Who are medically complex or fragile;
b. With excessive emergency room use;
c. With a mental health or substance abuse condition causing high functional impairment;
d. With untreated substance dependency based on the current DSM or other functional scale determined by the State;
e. Requiring assistance with two (2) ADLs or IADLs living in the community at medium to high risk;
f. With significant cognitive deficits; and/or
g. With contraindicated pharmaceutical use.

Care coordinators for Members in care coordination level 3 will provide and/or arrange for the following care coordination services:

a. Development and implementation of a person-centered plan;
b. Monitoring of the care plan and working with the individual to determine if the care plan is meeting the Member's identified needs;
c. Assessment of need for assignment to a health home;
d. Targeted health education, including disease management, based on the Member's individual diagnosis (as determined by the comprehensive needs assessment);
e. Semi-annual comprehensive needs assessment (according to the HSD standards) to determine if the care plan is appropriate and determine if a lower level of care coordination is needed;
f. Quarterly in-person visits with the Member; and
g. Monthly telephonic contact with the Member.

For Members in care coordination levels 2 and 3, the care coordinator will ensure at a minimum that the Member and the Representative (if applicable) participate in developing the comprehensive care plan. The MCO will ensure that care coordinators consult with the Member's PCP, specialists, Behavioral Health providers, other providers and interdisciplinary team experts, as needed when developing the comprehensive care plan. The MCO, through claims, will be informed of the admission but there is a lag in obtaining claims data. An MCO may also become aware of a Member's admission to a hospital through care coordination contacts. Should there be a significant change in a Member's health status following a hospitalization, the care coordinator shall reassess the Member and to determine if needs have changed and will notify the PCP if further services are determined to be necessary

4. Coverage and Authorization of Services

The MCO will provide and coordinate comprehensive and integrated health care benefits to each enrolled Member and will cover the physical health, behavioral health and long-term care services.

Physical, Behavioral Health and Long-Term Care services will not be denied solely because the Member has poor prognosis. Medically necessary services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible individual solely because of the diagnosis, type of illness or condition.

Services that are furnished in amount, duration and scope will be no less than those furnished to beneficiaries under fee-for-service (FFS) Medicaid.

The MCO, in making the determination of medical necessity of covered services will do so by: (i) evaluating individual physical and Behavioral Health information provided by qualified professionals who have personally evaluated the individual within their scope of practice, who have taken into consideration the individual's clinical history including the impact of previous treatment and service interventions and who have consulted with other qualified health care professionals with applicable specialty training, as appropriate; (ii) considering the views and choices of the individual or the individual's Representative regarding the proposed covered service as provided by the clinician or through independent verification of those views; and (iii) considering the services being provided concurrently by other service delivery systems. (iv) For HCBS, medical necessity is based on requiring assistance with 2 or more activities of daily living as defined in the uniform NM NF LOC instructions and criteria (8.312.2UR).

The MCO must ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise to understand the treatment of the Member's condition or disease, such as the MCO's medical director.

Each MCO states in the utilization management (UM) program description that compensation to individuals or entities that conduct UM does not provide incentive to deny, limit or discontinue medically necessary services.

The MCO must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

The MCO cannot arbitrarily deny or reduce the amount, duration, or scope of a covered service solely because of diagnosis, type of illness, or Member's condition.

The MCO may place appropriate limits on service: (i) on the basis of criteria approved by HSD, or the Collaborative to the extent it relates to a Behavioral Health service; or (ii) for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

For the processing of requests for initial and continuing authorization of services, the MCO will have and follow, and require that its subcontractors have and follow written policies and procedures for processing requests for initial and continuing authorizations for services.

The MCO will ensure that decisions for utilization management, Member education, coverage of services and other applicable areas are consistent with the guidelines, as well as have in effect mechanisms to ensure consistent application of UM criteria for authorization decisions.

The MCO will require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease, such as the MCO's medical director.

The MCO must notify the requesting provider, and give the Member written notice of any decision by the MCO to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements set forth in 42 C.F.R. § 438, Subpart F.

B. Structure and Operations Standards

1. Provider Selection

   In all provider agreements, the MCO must comply with the requirements specified in 42 C.F.R. § 438.214 and must maintain policies and procedures that reflect these requirements.

   Provider selection policies and procedures cannot discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment.

   Standards must meet NCQA standards and State and federal regulations for credentialing and re-credentialing, including 42 C.F.R. §§ 455.104, 455.105, 455.106 and 1002.3(b).

   MCOs may not employ an individual provider, an entity, or an entity with an individual who is an officer, director, agent, manager or person with more than five percent (5%) of beneficial ownership of an entity's equity, who has been convicted of crimes specified in the sections 1128 and 1128A of the Social Security Act, or who has a contractual relationship with an entity convicted of a crime specified in such section.

   MCOs shall comply with any additional requirements established by the state. MCOs shall:

   a. Conduct screening of all subcontractors and contract providers in accordance with the Employee Abuse Registry Act, NMSA 1978 § 27-7A-3, the New Mexico Caregivers Criminal History Screening Act, NMSA 1978, 29-17-2 et seq. and NMAC 7.1.9, the New Mexico Children's and Juvenile Facility Criminal Records Screening Act, NMSA 1978, §§ 32A-15-1 to 32A-15-4, PPACA and ensure that all subcontracts and contract Providers are screened against the New Mexico "List of Excluded Individuals/Entities" and the Medicare exclusion databases; and
   b. Maintain written policies and procedures on provider recruitment, retention, and termination of contract provider participation with the MCO. The recruitment policies and procedures shall describe how a MCO responds to a change in the network that affects access and its ability to deliver services in a timely manner.

2. Enrollee Information & Confidentiality

   a. The MCO will, at a minimum, have policies and procedures regarding the process for developing/creating, proofing, approving, publishing, and mailing the (i) Member ID

card, (ii) Member handbook, (iii) provider directory, (iv) Member newsletter, and (v) form letters within contractual standards and timeframes.

b. All written Member materials must be worded at or below a sixth (6th) grade reading level, unless otherwise approved in writing by HSD.

c. All written Member materials must be printed with the assurance of non-discrimination.

d. All written Member materials will be available in English and the prevalent language that includes all languages spoken by approximately five percent (5%) or more of the population with the exception of Native American languages for which there are not written forms and/or for which the State has not obtained consent from Tribal leadership to use the language. The MCO will certify that the translation of the information into the different languages has been reviewed by a qualified individual for accuracy.

e. Once a Member has requested a Member material in an alternative format or language, the MCO will (i) make a notation of the Member's preference in the system and (ii) provide all subsequent Member materials to the Member in such format unless the Member requests otherwise.

f. The Member handbook must be prior approved by HSD and be in a format that is easily understood. The Member handbook will include a table of contents and at a minimum comply with the following listed below as well as all necessary and mandated information in 42 C.F.R. §§ 438.10(f)(2) and (f)(6):

1) Describe the amount, duration and scope of all benefits, services and goods included in and excluded from coverage in sufficient detail to ensure that Members understand the benefits to which they are entitled;
2) Include information on how to access all services, including, but not limited to, EPSDT services, dental services, non-emergency transportation services, Behavioral Health services and Long-Term Care services;
3) Include information about the PCP, including: (i) how to select/change PCP and (ii) the role of the PCP and the procedures to be followed to obtain needed services;
4) Include information about care coordination including the role of care coordinators;
5) Include information on how to access services when out of State;
6) Describe how to report suspected Fraud and Abuse;
7) Describe how to access language assistance services for individuals with limited English proficiency;
8) Include information on the circumstances/situations under which a Member may be billed for services or assessed charges or fees; specifically that the provider

may not bill a Member or assess charges or fees except: (i) if a Member self-refers to a specialist or other provider within the network without following MCO procedures (e.g., without obtaining prior authorization) and the MCO denies payment to the provider, the provider may bill the Member; (ii) if a provider fails to follow the MCO's procedures, which results in nonpayment, the provider may not bill the Member; and (iii) if a provider bills the Member for non-Covered Services or for self-referrals, he or she shall inform the Member and obtain prior agreement from the Member regarding the cost of the procedure and the payment terms at time of service;

9) A statement that failure to pay for non-Covered Services will not result in a loss of Medicaid benefits;
10) Describe cost sharing including an explanation that providers and/or the MCO may utilize whatever legal actions are available to collect these amounts;
11) Detail procedures for obtaining benefits including services for which prior authorization or a referral is required and the methods for obtaining both;
12) Explain how to access after-hours, emergency and post-stabilization services, to also include: (i) what constitutes an emergency medical condition, emergency services and post-stabilization services as per definitions in 42 C.F.R. § 438.114(a); (ii) the fact that prior authorization is not required for emergency services; (iii) the process and procedure for obtaining emergency services, including use of the 911 telephone system or its local equivalent; and (iv) the fact that the Member has the right to use any hospital or other setting for emergency care;
13) Provide information regarding grievances, appeals and fair hearing procedures and timeframes including all pertinent information provided in 42 C.F.R. §§ 438.400 through 438.424;
14) Describe the Member's right to access a second opinion from a qualified health care professional within the network, or, if not available within the network, from a qualified health care professional outside of the network, at no cost to the Member;
15) Include information and written policies on Member rights and responsibilities, pursuant to 42 C.F.R. § 438.100 and NCQA's Standards and Guidelines for the Accreditation of MCOs;
16) Include written information concerning Advance Directives as described in 42 C.F.R. 489 Subpart I and in accordance with 42 C.F.R. § 422.128 and the Mental Health Care Treatment Decisions Act, NMSA 1978, 24-7B-1 et seq.;
17) Include language to clearly explain that a Native American Member may self-refer to an I/T/U for services;

18) Include information on how to contact a care coordinator and/or self-report a change in health status;
19) Include information on how to contact a Behavioral Health peer support specialist or wellness center;
20) Include health education and health literacy information as explained in this Agreement;
21) Include information regarding the Birthing Options Program; and
22) Include information on how to request disenrollment from an MCO.

3. The MCO must have written policies regarding the Member's, and/or Representatives' rights including, but not limited to, the guaranteed right to:

   a. Be treated with respect and with due consideration for his or her dignity and privacy;
   b. Receive information on available treatment options and alternatives, presented in a manner appropriate to the his or her condition and ability to understand;
   c. Make and have honored an Advance Directive consistent with State and federal laws;
   d. Receive Covered Services in a nondiscriminatory fashion;
   e. Participate in decisions regarding his or her health care, including the right to refuse treatment;
   f. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
   g. Request and receive a copy of his or her medical records and to request that they be amended or corrected as specified in 45 C.F.R. Part 164;
   h. Choose a Representative to be involved as appropriate in making care decisions; Provide informed consent;
   i. Voice grievances about the care provided by the MCO and to make use of the Grievance, Appeal and Fair Hearing processes without fear of retaliation;
   j. Choose from among contract providers in accordance with the MCO's prior authorization requirements;
   k. Receive information about covered services and how to access covered services, and contract providers;
   l. Be free from harassment by the MCO or its contract providers in regard to contractual disputes between the MCO and providers;
   m. Participate in understanding physical and Behavioral Health problems and developing mutually agreed-upon treatment goals;
   n. The MCO will ensure that each Member (and/or as appropriate, Representative) is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the way the MCO or its contract providers treat the Member (and/or Representative);

o. Require that Member information be kept confidential, as defined by federal and State statutes or regulations;
p. Members and/or Representatives, to the extent possible, have a responsibility to: Provide information that the MCO and its contract providers need in order to care for the Member;
q. Follow the plans and instructions for care that they have agreed upon with their providers; and
r. Keep, reschedule, or cancel a scheduled appointment rather than to simply fail to keep it.

4. Enrollment/Disenrollment

a. Recipients who are eligible for Medicaid in the State of New Mexico and receiving services as of October 1, 2013, must select a Centennial Care MCO by December 1, 2013, unless excluded from mandatory enrollment in Centennial Care. Recipients required to enroll in Centennial Care who do not select an MCO by December 1, 2013 will be auto assigned to an MCO. Recipients required to enroll in Centennial Care who become eligible after October 1, 2013 but before January 1, 2014 must select an MCO at the time of applying for Medicaid eligibility.

b. Individuals (newly Medicaid eligible) determined eligible for Centennial Care on or after January 1, 2014, and who did not select or were not assigned to an MCO must select an MCO at the time of applying for Medicaid eligibility. Recipients who fail to select an MCO at such time will be auto assigned to an MCO.

c. HSD will auto assign a Recipient to an MCO in specified circumstances, including but not limited to (i) the Recipient does not select an MCO at the time of eligibility or (ii) the Recipient cannot be enrolled in the requested MCO (e.g., the MCO is subject to and has reached its enrollment limit).

d. The auto assignment process will consider the following:

1) If the Recipient was previously enrolled with an MCO and lost eligibility for a period of two (2) months or less, the Recipient will be re-enrolled with that MCO;
2) If the Recipient has family members in an MCO, the Recipient will be enrolled in that MCO;
3) If the Recipient is a newborn, the Recipient will be assigned to his or her mother's MCO; and

4) If none of the above applies, the Recipient will be assigned using default logic that randomly assigns Recipients to MCOs.

HSD may modify the auto assignment algorithm to incorporate criteria including but not limited to quality measures, cost or Utilization Management performance.

e. Newborns

1) When a child is born to a mother enrolled in Centennial Care, the hospital or other provider will complete a Notification of Birth, MAD Form 313, or its successor, prior to or at the time of discharge. HSD will ensure that upon receipt of the MAD Form 313 the eligibility process is immediately commenced and that upon completion of the eligibility process the newborn is enrolled into his or her mother's MCO;
2) Medicaid eligible newborns are eligible for a period of twelve (12) months, starting with the month of birth. The newborn will be enrolled retroactively to the month of birth with the mother's MCO;
3) When a Medicaid-eligible child is born to a mother on the New Mexico Health Insurance Exchange and the mother's Qualified Health Plan is also a Centennial Care MCO, the newborn will be enrolled retroactively to the month of birth with that Centennial Care MCO; and
4) When a Medicaid-eligible child is born to a mother on the New Mexico Health Insurance Exchange and the mother's Qualified Health Plan is not a Centennial Care MCO, the newborn will be auto assigned and enrolled in a Centennial Care MCO retroactively to the month of birth. The mother will have one (1) opportunity anytime during the ninety (90) Calendar Days from the effective date of enrollment to change the newborn's MCO assignment.

f. The MCO will accept Recipients in accordance with 42 C.F.R. § 434.25 and will not discriminate against, or use any policy or practice that has the effect of discriminating against, an individual on the basis of (i) health status or need for services or (ii) race, color, national origin, ancestry, spousal affiliation, sexual orientation and/or gender identity.

g. After enrolling with the MCO (whether as the result of selection or auto assignment), Members will have one (1) opportunity anytime during the ninety (90) calendar day period immediately following the effective date of enrollment with the MCO to request to change MCOs. After exercising this right to change MCOs, a Member will remain with the MCO until the annual choice period unless disenrolled.

h. HSD will provide an opportunity for Members to change MCOs every twelve (12) months at the time of the Member’s redetermination. Members who do not select another MCO during their annual choice period will be considered to have chosen to remain with their current MCO.

i. The MCO will accept all Members transferring from any MCO as authorized by HSD. The transfer of membership may occur at any time during the year. The former MCO will not be responsible for payment of any covered services incurred by Members transferred to the new MCO after the effective date of transfer to the new MCO.

j. The MCO cannot, under any circumstances, disenroll a Member. The MCO will not request disenrollment because of a change in the Member's health status, or because of the Member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO, seriously impairs the MCO's ability to furnish services to either this particular Member or other Members).

k. A Member has the opportunity to change MCOs during the first ninety (90) calendar days of a twelve (12) month period; the Member will remain with the MCO until his or her twelve (12) month period expires.

l. A Member may request to be disenrolled from the MCO for cause at any time, even during a lock-in period. The Member must submit a written request to HSD for approval. HSD must respond no later than the first calendar day of the second month following the month in which the Member files the request. If HSD does not respond, the request will be deemed approved. The Member will have access to HSD’s fair hearing process if he/she is dissatisfied with the determination denying the request to disenroll. The following are causes for Member initiated disenrollment:

   1) The Member moves out of the State of New Mexico;
   2) The MCO does not, because of moral or religious objections, cover the service the Member seeks;
   3) If HSD imposes intermediate sanctions on the MCO;
   4) If the Member is automatically re-enrolled if temporary loss of Medicaid eligibility caused the Recipient to miss the Recipient’s annual disenrollment opportunity during the annual choice period;

5) The Member needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the network, and the Member's PCP or another provider determines that receiving the services separately would subject the Member to unnecessary risk; or
6) Other reasons, including but not limited to, poor quality of care, lack of access to covered services, or lack of access to providers experienced in dealing with the Member's health care needs.

5. Grievance Systems

The MCO will have a grievance system in place for Members that includes a process related to the expressions of dissatisfaction and an appeal process related to an MCO action. A Member must first exhaust the MCO's grievance and appeal system prior to requesting a State fair hearing.

a. In implementing these processes, the MCO will, at a minimum:

1) Adopt written policies and procedures describing how the Member may register a grievance or an appeal with the MCO and how the MCO resolves the grievance or appeal;
2) Provide a copy of its grievance and appeal policies and procedures to all contract providers;
3) Comply with the requirements in 42 C.F.R. § 438.406(a); and
4) Ensure that punitive or retaliatory action is not taken against a Member or a provider that files a grievance and/or an appeal, or against a provider that supports a Member's grievance and/or appeal.

During the first six months of Centennial Care, the state must review complaint, grievance and appeal logs for each MCO and data from the state or operated incident management system on a monthly basis. The state will use this information to implement any immediate corrective actions necessary.

6. Subcontract Relationships and Delegation

If the MCO delegates responsibilities to a subcontractor, the MCO must ensure that the subcontracting relationship and subcontracting document(s) comply with federal requirements, including but not limited to compliance with the applicable provisions of 42 C.F.R. §§ 438.230(b) and 434.6 and contract requirements.

The MCO will evaluate and certify to HSD that the prospective subcontractor has the ability to perform the activities to be delegated and implement policies and procedures for the oversight of the subcontractor's performance of the subcontracted functions.

The MCO will ensure that the subcontractor meets all standards of performance mandated by HSD for the Centennial Care program. These include, but are not limited to: a) use of appropriately qualified staff, b) the application of clinical practice guidelines and Utilization Management, c) reporting capability and ensuring Members' access to care.

The MCO must provide the information specified in 42 C.F.R. § 438.10(g)(1) about its grievance and appeals system to all subcontractors at the time they enter into mutual contract.

The MCO must monitor the subcontractor's performance on an ongoing basis and subject it to formal review, on at least an annual basis, consistent with NCQA standards and State MCO statutes and regulations:

a. The MCO will identify deficiencies or areas for improvement, and the MCO and the subcontractor shall take corrective action as necessary;
b. The MCO must conduct an annual evaluation of its subcontractors that includes policies and procedures, an audit of applicable files or records and implementation of a corrective action plan if warranted. If a subcontractor is under a corrective action plan, the MCO must conduct the annual review onsite;
c. The MCO must notify HSD, and the Collaborative to the extent Behavioral Health services are involved, if any of the subcontractors are under a corrective action plan;
d. HSD maintains the right to review all transactions from a subcontractor to the MCO at any time; and
e. In the event that any subcontractor is incapable of performing the service contracted for by the MCO, the MCO will assume responsibility for providing the services that the subcontractor is incapable of performing. Upon HSD's request, the MCO will provide any covered services directly until the MCO identifies and contracts with a provider to provide such services.

C. Measurement and Improvement Standards

1. Practice Guidelines

The MCO must adopt practice guidelines that meet the following requirements:

a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
b. Consider the needs of the Members;
c. Are adopted in consultation with contract providers; and
d. Are reviewed and updated every two (2) years.

The MCO must disseminate the guidelines to all affected contract providers and, upon request, to Members and ensure that decisions for utilization management, Member education, coverage of services and other applicable areas are consistent with the guidelines.

2. Quality Assessment and Performance Improvement Program

In order to have an ongoing quality assessment and performance improvement program, each MCO must do the following:

a. The MCO will participate in meetings with the Native American Advisory Board. At a minimum, such meetings will occur quarterly. Native American Advisory Board members will serve to advise the MCO on any issues pertaining to Native Americans including, but not limited to, issues concerning operations, service delivery and quality of all covered services (e.g., Behavioral Health, physical health and Long-Term Care), Member rights and responsibilities, the resolution of Member grievances and appeals, and claims processing and reimbursement issues.

b. The MCO will convene and facilitate a Member Advisory Board and adhere to all HSD requirements. Member Advisory Board members shall serve to advise the MCO on issues concerning service delivery and quality of all Covered Services (e.g., Behavioral Health, physical health and Long-Term Care), Member rights and responsibilities, resolution of Member grievances and appeals and the needs of groups represented by Member Advisory Board members as they pertain to Medicaid.

c. The Member Advisory Board will consist of Members representing all Centennial Care populations, family members, and providers. The MCO will have an equitable representation of its Members in terms of race, gender, special populations, and New Mexico’s geographic areas.

d. The MCO's Member Advisory Board will keep a written record of all attempts to invite and include its Members in its meetings. The Member Advisory Board roster and minutes will be made available to HSD ten (10) Calendar Days following the meeting date.

e. The MCO will hold quarterly, centrally located Member Advisory Board meetings throughout the term of the Agreement. The MCO will advise HSD ten (10) Calendar Days in advance of meetings to be held.

f. In addition to the quarterly meetings, the MCO shall hold at least two (2) additional statewide Member Advisory Board meetings each Contract year that focus on Member issues to help ensure that Member issues and concerns are heard and addressed. Attendance rosters and minutes for these two (2) statewide meetings shall be made available to HSD within ten (10) Calendar Days following the meeting date.

g. The MCO will ensure that all Member Advisory Board members actively participate in deliberations and that no one Board member dominates proceedings in order to foster an inclusive meeting environment.

h. The MCO will comply with State and federal standards for quality management and quality improvement. The MCO will:

   1) Establish QM/QI program based on a model of continuous quality improvement using clinically sound, nationally developed and accepted criteria;
   2) Recognize that opportunities for improvement are unlimited; that the QM/QI process shall be data driven, requiring continual measurement of clinical and non-clinical processes driven by such measurements; requiring re-measurement of effectiveness and continuing development and implementation of improvements as appropriate; and, shall reflect Member and contract provider input;
   3) Have a QM/QI annual program description that includes goals, objectives, structure, and policies and procedures that shall result in continuous quality improvement;
   4) Review outcome data at least quarterly for performance improvement, recommendations and interventions;
   5) Have a mechanism in place to detect under-and-over utilization of services;
   6) Have access to, and the ability to collect, manage and report to HSD data necessary to support the QM/QI activities;

7) Have assessment tools to assess appropriateness of care furnished to enrollees with special health care needs through (Health Risk Assessment and Comprehensive Needs Assessment);
8) Establish a committee to oversee and implement all policies and procedures; and Implement Performance Improvement Projects (PIPs) identified internally by the CONTRACTOR in discussion with HSD or implement PIPs as directed by HSD. At a minimum, the CONTRACTOR shall implement PIPs in the following areas: one (1) on Behavioral Health, one (1) on services to children, and PIPs as required by the Adult Medicaid Quality Grant. PIPs work plan and activities must be consistent with PIPs as required by the Adult Medicaid Quality Grant, federal/State statutes, regulations and Quality Assessment and Performance Improvement Program requirements for pursuant to 42 C.F.R. § 438.240. For more detailed information refer to the "EQR Managed Care Organization Protocol" available at http://www.medicaid.gov/Medicaid-CHIP- Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External- Quality-Review.html

i. Submit an annual QM/QI written evaluation to HSD that includes, but is not limited to:

1) A description of ongoing and completed QM/QI activities;
2) Measures that are trended to assess performance;
3) Findings that incorporate prior year information and contain an analysis of any demonstrable improvements in the quality of clinical care and service;
4) Development of future work plans based on the incorporation of previous year findings of overall effectiveness of QM/QI program;
5) Demonstrate that active processes are implemented that measure associated outcomes for assessing quality performance, identifying opportunities for improvement, initiating targeted quality interventions and regularly monitoring each intervention's effectiveness;
6) Demonstrate that the results of QM/QI projects and reviews are incorporated in the QM/QI program;
7) Incorporate annual HEDIS results in the following year's plan as applicable to HSD specific programs; and
8) Communicate with appropriate contract providers the results of QM/QI activities and provider reviews and use this information to improve the performance of the contract providers, including technical assistance, corrective action plans, and follow-up activities as necessary.

j. As part of the QI program for Centennial Care, the MCO must conduct an annual survey that assesses Member satisfaction with the quality, availability and accessibility of care. The Member surveys will address:

  1) Member receipt of educational materials;
  2) Member satisfaction with care coordination and involvement in care coordination processes, including development of the comprehensive care plan;
  3) Children with Chronic Conditions (CCC) to assess Member satisfaction as part of NCQA requirements; and
  4) The use of additional survey questions that is relevant to the Centennial Care population, as specified by HSD.

k. The MCO will also implement the Mental Health Statistics Improvement Project (MHSIP) for Members identified as having mental health needs.

l. The MCO must conduct at least one (1) annual Provider Satisfaction Survey that covers contract providers.

m. The MCO will have mechanisms in place to incorporate all survey results in the QM/QI plan for program and systems improvements.

3. Health Information Systems

The State has been successful in implementing systems to support the goals of the program. Systems are in place to collect encounter, provider network, complaint, quality, and satisfaction data. Plans are also required to submit financial reports. New data collection efforts include case management data and functional assessment data. The MCOs have developed successful information systems that allow them to collect and submit required data and reports.

Many health plans have implemented electronic health records and established internal registries to assist them in disease management, such as diabetes, asthma and high risk prenatal care. Statewide and regional health registries such as the NM immunization registry have been useful to plans in measuring enrollee compliance with HEDIS immunization standards.

The MCO must maintain system hardware, software, and information systems (IS) resources sufficient to provide the capability to: Accept, transmit, maintain and store electronic data and enrollment roster files; Accept, transmit, process, maintain and report specific information necessary to the administration of the State's Centennial Care

programs, including, but not limited to, data pertaining to providers, Members, Claims, Encounters, Grievance and Appeals, disenrollment for other than loss of Medicaid eligibility and HEDIS and other quality measures.

MCO information systems must comply with the most current federal standards for encryption of any data that is transmitted via the internet by the MCO or its subcontractors and transmit electronic Encounter Data to HSD according to Encounter Data submission standards.

The annual HEDIS audit reports for assessment of enrollment and claims data systems will verify data integrity.

MCOs will transmit to HSD a daily update file that contains Member information specific to copayment amounts paid to date, nursing facility level of care, Community Benefit status, Behavioral Health status, care coordination level, Health Home status, PCP assignment, disability status and identifying information.

MCOs will make system information available to duly authorized representatives of HSD and other State and federal agencies to evaluate, through inspections, audits, or other means, the quality, appropriateness and timeliness of services performed.

MCOs maintain websites for dispersing information to providers and Members, to receive comments electronically and to respond to comments when appropriate.

IV. A. IMPROVEMENT AND INTERVENTIONS

The State will utilize a variety of interventions to improve the quality of care delivered by the MCOs. Some of these will include:

1. Disease Management (DM) which is a comprehensive plan following nationally recognized components for chronic disease interventions including population identification/stratification, collaborative practice models, patient self-management education, evidence-based practice guidelines, process and outcomes measurements and internal quality improvement processes. HSD/MAD directed DM Programs apply a strategy of delivering health services using interdisciplinary clinical teams, continuous analysis of relevant data, and cost-effective technology to improve the health outcomes of individuals with specific diseases or health conditions. HSD/MAD seeks to improve the health status of all individuals in the population with specific diseases. DM programs implemented by the MCOs are used to measure the ability to impact health outcomes. The MCO must improve its ability to manage chronic illnesses/diseases through DM protocols in order to meet goals based on established targets.

The MCOs will provide disease management strategies to Members with identified chronic conditions as part of its care coordination processes and activities. The MCOs' DM strategies may include population identification/stratification, collaborative practice models, patient self-management education, evidence-based practice guidelines, process and outcomes measurements and internal quality improvement processes.

The MCOs will:

a. Participate in DM projects annually;
b. Provide comprehensive DM for a minimum of two (2) chronic disease states, one applicable/relevant to the adult population and one to the pediatric population, if applicable, using strategies consistent with nationally recognized DM guidelines, such as those available through the Agency of Healthcare Research and Quality's (AHRQ), NQMC web site, or the Care Continuum Alliance (formerly the Disease Management Association of America);
c. Submit cumulative data-driven measurements with written analysis describing the effectiveness of its DM interventions as well as any modifications implemented by the MCO to improve its DM performance. All DM data submitted to HSD will be New Mexico Medicaid-specific;
d. Submit to HSD the CONTRACTOR's DM plan, which shall include a description of the strategies and interventions, the overall and measurable objectives, and targeted interventions. The MCO will also submit to HSD its methodology for identifying other diseases/conditions for potential DM strategies and interventions; and
e. Submit to HSD a quantitative and qualitative evaluation of the efficacy of the prior year's DM strategies; document how well goals were addressed, such as identification, enrollment, targeted interventions, and outcomes.

2. Utilization Management (UM)

The MCO will establish and implement a UM system that follows national UM standards and promotes quality of care, adherence to standards of care, the efficient use of resources, Member choice, and the identification of service gaps within the service system.

The UM program will:

a. Ensure that Members receive services based on their current condition and effectiveness of previous treatment;

b. Ensure that services are based on the individual goals, history of the problem/illness, its context, and desired outcomes;
c. Assist Members and/or their Representatives in choosing among providers and available treatments and services;
d. Emphasize relapse and crisis prevention, not just crisis intervention;
e. Detect over-and-under utilization of services to assess quality and appropriateness of services and to assess quality and appropriateness of care furnished to Members with special health care needs.

The MCO shall comply with State and federal requirements for Utilization Management including but not limited to 42 C.F.R. Part 456.

The MCO will manage the use of limited resources and maximize the effectiveness of care by evaluating clinical appropriateness, and authorizing the type and volume of services through fair, consistent and culturally competent decision making processes while ensuring equitable access to care and a successful link between care and outcomes.

The MCO will ensure that the Pharmacy and Therapeutics Committee membership includes behavioral health expertise to aid in the development of pharmacy and practice guidelines for PCPs regarding psychotropic and antidepressant medications.

The MCO will perform a comprehensive UM program evaluation that includes an evaluation of the overall effectiveness of the UM program, an overview of UM activities and an assessment of the impact of the UM program on management and administrative activities. The review and analysis of any impact from the previous year will be incorporated in the development of the following year's UM work plan.

3. Care Coordination under Centennial Care will require collaboration with various state agencies. The MCOs will work with the New Mexico Children, Youth and Families Department (CYFD) and other State agencies to promote early identification of children who are engaging in delinquent or high-risk factors including exhibiting signs of serious emotional disturbance. The MCO will coordinate services with the CYFD Protective Services ("PS") and Juvenile Justice Services ("JJS") divisions, including discharge planning and will participate in all FS, PS, and JJS clinical staffing reviews, including the CYFD Care Coordination Protocol process. Upon request, the MCO will participate in the PS Team Decision-Making ("TDM") and JJS Multi-Disciplinary Team ("MDT") meetings. The MCO will promote coordination between juvenile detention facilities and the MCO's contract providers to establish a process to communicate the physical health and behavioral health needs of juveniles at intake and discharge and to establish

continuity of care between the juvenile detention facility and the MCO. The MCO will facilitate that coordination if requested. Additionally, if requested by an Indian Tribe, Nation, or Pueblo located partially or wholly in New Mexico, the MCO will negotiate in good faith to enter into agreements to develop assessment and treatment protocols and procedures to ensure that services are provided to children in Tribal custody or under Tribal supervision who are in need of such services.

4. The Patient-Centered Medical Home (PCMH) initiative will continue and expand under Centennial Care. The patient-centered initiatives support HSD's commitment to improving health status, achieving superior clinical outcomes and improving service delivery while reducing administrative burdens. MCOs are directed to establish a patient-centered initiative based on the NCQA PCMH Recognition Program. The MCO will work with PCP contract providers to implement PCMH programs. PCMHs will not be required to attain NCQA recognition but will be encouraged to achieve recognition as soon as possible. The MCO will ensure that the PCMH provides patient-centered care, practices evidence-based medicine and clinical decision supports, participates in continuous quality improvement and voluntary performance measurement, engages patients to actively participate in decision-making, provides feedback, uses health information technology to support care delivery and participates in Health Information Exchange initiatives.

   The MCO will support engagement and transition of primary care practices to PCMHs by focusing on the following areas: Screening/identification and targeting of PCMH participants including but not limited to: (i) Members with an identified disease state/condition aligned with the MCO's proposed disease management programs; and (ii) Members identified with a higher level of need for continuity of care such as those with a Behavioral Health diagnosis including substance abuse that adversely effects the Member's life, co-morbid health conditions or Members receiving nursing facility level of care.

   The MCO will:

   a. Maintain continuous, accessible, comprehensive and coordinated care using community-based resources as appropriate;
   b. Focus care on prevention, chronic care management, reducing emergency room visits and unnecessary hospitalizations and improving care transitions;
   c. Use access and quality measures (HEDIS and surveys), as defined by HSD;
   d. Demonstrate improved health status and outcomes for Members as defined by HSD;

e. Use measures to analyze the delivery of services and quality of care, over and underutilization of services, disease management strategies and outcomes of care;
f. Promote adoption of Health Information Technology ("HIT") and supporting the exchange of electronic health information and
g. Promote integration between primary care and other providers of Covered Services through care coordination as well as data exchange; specifically, data that may be used to support decision making and continuous quality improvement, which may include the release of Medicaid Claims/Encounter Data, MCO Claims/Encounter Data and MCO authorization data as directed by HSD.

5. The state will work with the MCOs to develop a Health Home initiative as authorized under Section 2703 of the Patient Protection and Affordable Care Act ("PPACA").

   The MCO will ensure that the Health Homes provide care coordination functions for Members enrolled in a Health Home and will maintain administrative responsibility and oversight of care coordination and reporting of health home services and activities.

6. For home and community based services the State and/or the EQRO will annually audit service plans and NF LOCs at a 95% confidence intraval ensure that:

   a. Services are being provided by qualified providers;
   b. Criteria are applied appropriately and individuals receiving services have met the eligibility requirements for services; and
   c. Service plans for enrollees are created and implemented based on identified needs and individual goals and preferences.

   In summary: The disease management program promotes member education and self-management of chronic diseases with the utilization of best practices. Member education promotes well informed choices in self-care together with preventative interventions. Utilization management directs efficiency in the utilization of available resources, determination of appropriate levels of care as well as detection of over and underutilization of resources. Collaboration with state agencies, establishment of PCMHs and health homes promote care coordination, care integration, use of community resources and identification of special need populations. Payment reforms will reward positive quality of care outcomes.

Summary Table: State Goals with Interventions:

State Goals	Interventions
1. Create a unified, comprehensive service delivery system to assure cost-effective care and to focus on quality over quantity.	a. Utilization Management Program to assess quality and appropriateness of care with efficient resource utilization; b. HEDIS measures, an integrated HIE system, performance measure and performance improvement projects to assess the quality of care.
2. Assure equity in the delivery of high quality preventive, chronic illness, and rehabilitative care and personalized services across the populations and communities served.	a. Disease Management program to identify populations with chronic conditions and promote member wellness.
3. Slow the rate of cost growth in costs over time through better management of care while avoiding cuts.	a. Establishment of a comprehensive care coordination system to identify individuals with complex needs.
4. Streamline and modernize the program in preparation for the potential increase in membership of up to 175,000 people beginning January 1, 2014.	a. Establishment of a comprehensive care coordination system to identify individuals with complex needs.

B. Intermediate Sanctions

If HSD determines that the MCO is not in compliance with one or more requirements in the Centennial Care contract, HSD may issue a notice of deficiency, identifying the deficiency(ies) and follow-up recommendations/requirements (either in the form of a Corrective Action Plan (CAP) or an HSD Directed Corrective Action Plan (DCAP)). A notice from HSD of noncompliance directing a CAP or DCAP will also serve as a notice for sanctions and/or liquidated damages in the event HSD determines that sanctions and/or liquidated damages are also necessary.

1. The MCO is required to provide CAPs to HSD within fourteen (14) calendar days of receipt of a noncompliance notice from HSD. CAPs are subject to review and approval by HSD.

2. If HSD imposes a DCAP on the MCO, the MCO will have fourteen (14) calendar days to respond to HSD.

3. If the MCO does not effectively implement the CAP/DCAP within the timeframe specified in the CAP/DCAP, HSD may impose additional remedies or sanctions:

a. Suspension of auto-assignment of Members who have not selected an MCO;

b. Suspension of enrollment in the MCO;

c. Notification to Members of their right to terminate enrollment with the MCO without cause as described in 42 C.F.R. § 438.702(a)(3);

d. Disenrollment of Members by HSD;

e. Suspension of payment for Members enrolled after the effective date of the sanction and until CMS or HSD is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur;

f. Rescission of marketing consent and suspension of the MCO's marketing efforts;

g. Recoupment of damages in an amount equal to the costs of obtaining alternative health benefits to a Member in the event of the MCO's noncompliance in providing covered services. The damages will include the difference in the capitated rates that would have been paid to the MCO and the rates paid to the replacement health plan. HSD may withhold payment to the MCO for damages until such damages are paid in full;

h. Civil monetary penalties as described in 42 C.F.R. § 438.704;

i. Monetary penalties, depending on severity of infraction, up to five percent (5%) of the MCO's Medicaid capitation payment for each month in which the penalty is assessed;

j. Appointment of temporary management or any portion thereof for an MCO as provided in 42 C.F.R. § 438.706 and the MCO will pay for any costs associated with the imposition of temporary management; and

k. Additional sanctions permitted under federal or State statute or regulations that address areas of noncompliance.

C. Health Information Technology

1. HSD maintains oversight responsibility for evaluating and monitoring the volume, completeness, timeliness, and quality of encounter data submitted by the MCO. If the MCO elects to contract with a subcontractor, the MCO must ensure that the subcontractor complies with all claims and encounter requirements. The MCO must submit all encounter data for all services performed to HSD. The MCO is responsible for the quality, accuracy, and timeliness of all encounter data submitted to HSD. HSD will communicate directly with the MCO any requirements and/or deficiencies regarding completeness, quality, accuracy and timeliness of encounter data, and not with any third party contractor.

2. With respect to encounter submission, the MCO will provide encounter data to HSD by electronic file transmission using the HIPAA 837 balancing rules and NCPDP formats according to HIPAA transaction and code sets and operating rules using HSD approved, standard protocols; comply with CMS and HIPAA standards for electronic transmission, security and privacy (also applies to subcontractors); submit to HSD all encounters in accordance with the HIPAA Technical Review Guides, New Mexico's Medicaid MCO Companion Guides, any HIPAA operating rules that may be issued, New Mexico's procedures for successful submission for files to the translator operated by New Mexico's Medicaid fiscal agent and any specific information included in the MCO Systems Manual; and make changes or corrections to any systems, processes or data transmission formats as needed.

3. The MCO will maintain system hardware, software, and information systems (IS) resources sufficient to provide the capability to: accept, transmit, maintain and store electronic data and enrollment roster files; accept, transmit, process, maintain and report specific information necessary to the administration of the State's Centennial Care programs, including, but not limited to, data pertaining to providers, Members, claims, encounters, grievance and appeals, disenrollment for other than loss of Medicaid eligibility and HEDIS and other quality measures; comply with the most current federal standards for encryption of any data that is transmitted via the internet by the MCO or its

subcontractors; conduct automated claims processing with current National Provider Identification Number (NPI) for health care providers and FEIN/SSN numbers for atypical providers in HIPAA compliant formats; have an automated access system for providers to obtain Member enrollment information that includes the cross-reference capability of the system to the Member's ten (10) digit Medicaid identification number designated by HSD to the Member's social security number as a means of identifying the Member's most current benefits such as providing the Member's category of eligibility.

4. Additionally, provider network information requirements include accepting a provider master file from HSD that identifies all Medicaid enrolled providers; Member information requirements include maintaining accurate Member eligibility and demographic data to include but not be limited to category of eligibility, care coordination level, nursing facility level of care, community benefit status, copayment maximum, copayment spent amount, Medicare status, health home status, behavioral health needs, age, sex, race, residence county, parent/non parent status, Native American status, institutional status, and disability status on its system's database consistent with HSD requirements. This requirement also applies to any subcontractor who maintains a copy of the Member enrollment files for the purpose of distributing eligibility or enrollment information to providers for verifying Member eligibility.

5. The MCO annual HEDIS audit report will assess the accuracy and completeness of data.

6. The MCOs will partner with HSD in the management of current and future data exchange formats and methods and in the development and implementation planning of future data exchange methods not specific to HIPAA or other federal effort.

7. The MCOs will participate in and, as may be directed, implement any Health Information Exchange or Electronic Health Record initiatives undertaken by HSD or other entities.

V. DELIVERY SYSTEM REFORMS

1. The populations to be included in Centennial Care will include:
   a. All CoLTS members, including Native Americans (CoLTS is a managed care program that provides acute, ancillary and long-term care services to some Medicaid and Medicare eligibles);
   b. PCO recipients (Medicaid eligibles requiring personal care services);
   c. CoLTS “C” Waiver recipients (Medicaid eligibles who are disabled and elderly);
   d. Nursing Facility (NF) residents;
   e. Full dual eligibles;
   f. Most individuals receiving Medicaid through the traditional Fee-for-Service model;
   g. All Salud! Members (Salud! is a managed care program that provides acute and ancillary services to some Medicaid eligibles);
   h. Mi Via Waiver recipients who meet NF level-of-care (self-directed waiver);
   i. Native American full dual eligibles;
   j. Native Americans with long-term care needs;
   k. Those enrolled in CHIP;
   l. Individuals receiving services under the AIDS Waiver; and
   m. Newly eligible expansion for adults.

2. The reasons for incorporation of these populations into Centennial Care include:
   a. The program is expensive, consuming about 16% of the current State budget up from 12% last State fiscal year (SFY) and rising to 20% next SFY. Specifically, in 2011, New Mexico and the federal government spent approximately $3.8 billion on Medicaid services for New Mexicans. The rate of growth in costs precedes the approximately 175,000 additional people who will be added to the program beginning January 2014 under the PPACA and for whom the State will ultimately bear some of the costs.
   b. The New Mexico Medicaid program is also administratively complex. Today, the program operates under 12 separate waivers as well as a fee-for-service (FFS) program for those either opting out of or exempt from managed care, and seven different health plans execute this complicated delivery system.
   c. The State is not necessarily buying quality; rather, rates are determined and payments made based on the quantity of services offered. The State pays for services without regard to whether they represent best practices in medicine and without regard to

whether those services help make people healthier or help them manage complex medical/behavioral conditions.

For all of these reasons, New Mexico believes that now is the time to modernize Medicaid to assure that the State is buying the most effective, efficient health care possible for our most vulnerable and needy citizens and to create a sustainable program for the future.

The performance measures and reasons for selecting them are stated in Section I.A.4, page 9.

3. The state will work with the MCOs to develop Payment Reform Projects to begin the process of recognizing and rewarding providers based on outcomes, rather than the volume of services delivered. Proposed projects include: payment reform projects for the ambulatory treatment of adult diabetes and pediatric asthma; and, payment reform project focused on bundled payments for hospital care and follow up of Members with diagnoses of pneumonia and congestive heart failure.

   The MCOs will have the option to develop other pay for performance initiatives for physical health, behavioral health and long-term care services with the approval of HSD.

   HSD will require a collaborative approach to the development of the payment reform projects among all Centennial Care MCOs. It is expected that the MCOs will also collaborate with other entities, including: (i) the New Mexico Hospital Association; (ii) the New Mexico Primary Care Association; (iii) the New Mexico Medical Society; (iv) the Albuquerque Coalition for Health Care Quality (AC4HCQ); and (v) I/T/Us.

   The MCO, in collaboration with the other Centennial Care MCOs and the aforementioned partners, will develop a project model subject to approval by HSD and will include:

   a. Development of baseline data and an evaluation methodology;
   b. Definition of best practices in managing the project populations;
   c. Development of performance measures; and
   d. Development of provider incentives to reduce unnecessary utilization and improve patient outcomes.

All decisions about the goals and the design of the payment reform pilots are subject to final approval by HSD, including:

a. Minimum requirements for provider participation;
b. Program goals;
c. Clinical measures;
d. Provider incentives, including gain-sharing/shared savings arrangements between the MCOs and providers; and
e. Establishment of a common methodology for measurement and evaluation.

4. As part of the MCO contract, each MCO is required to implement Performance Improvement Projects (PIPs), at a minimum, in the following areas: one on behavioral health, one on services to children, one on long-term care and one on women's health, and have a PIPs work plan and activities that are consistent with federal/State statutes, regulations and quality assessment/PIP requirements pursuant to 42 CFR 438.240.

5. The Special Terms and Conditions (STCs) requirements directly related to the populations included in Centennial Care, in summary, are as follows:

   1) The demonstration population will receive comprehensive benefits that are at least equal in amount, duration and scope as those described in the State Plan;
   2) Enrollees who meet the NF level of care criteria (as defined by the State) will be eligible for the community benefit.
   3) Certain individuals enrolled who are deaf and blind may access the benefit of community interveners. A community intervener is a trained profession who meets the criteria as determined by the State. The intervener works one-on-one with deaf-blind individuals who are five years and older to provide connections to other people and the environment.
   4) Enrollees with special health care needs (those who have or are at increased risk for a disease, defect or medical condition that may hinder the achievement of normal physical growth and development and who also require health and related services of a type or amount beyond that required by individuals generally) must have direct access to a specialist, as appropriate for the individual's health care condition, as specified in 42 CFR 438.208(c)(4).
   5) Demonstrating Network Adequacy. Annually, each MCO must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area and offers an adequate range of preventive, primary, pharmacy,

behavioral health, specialty, and HCBS services for the anticipated number of enrollees in the service area.

6) Administrative Authority. HSD will maintain administrative authority for operation of the Centennial Care program. The state maintains oversight of the program by: establishing MCO requirements (via the Centennial Care contract), regularly monitoring MCO performance through regular meetings and reporting and imposing sanctions and penalties when MCOs are not meeting all required standards

   a. HSD and/or the EQRO will do random audits of HCBS service plans to endure service plans both meet the needs identified in the CNA, and to ensure those services were received by the member. This will be reported to CMS annually and as required by the CMS Special Terms and Conditions (STCs).

7) The state must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees in the demonstration as well as:

   a. The number and types of providers available to provide covered services to the demonstration population;
   b. The number of network providers accepting the new demonstration population; and
   c. The geographic location of providers and demonstration populations, as shown through GeoAccess, similar software or other appropriate methods.

8) The state must submit the documentation required in the three aforementioned subparagraphs 1) – 3) to CMS at an agreed upon time prior to program implementation, as well as with each contract renewal or renegotiation, or at any time that there is a significant impact to each MCO’s operation, including service area reduction and/or population expansion.

9) <u>Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).</u> The MCOs must fulfill the state’s responsibilities for coverage, outreach, and assistance with respect to EPSDT services that are described in the requirements of sections

1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements), and 1905(r) (definitions).

10) Required Monitoring Activities by State and/or External Quality Review Organization (EQRO). The State's EQRO process will meet all the requirements of 42 CFR §438 Subpart E. To meet these requirements, the EQRO conducts three mandatory Centers for Medicare & Medicaid Services (CMS) EQR activities based on Letters of Direction (LODs) from HSD. The data collection activities and measures include the following:

   a. Compliance Monitoring: These evaluations were designed to determine the MCOs compliance with their contract and with state and federal regulations through review of individual health plan records to evaluate implementation of the compliance standards.
   b. Validation of Performance Measures (PMs): The EQRO validated each of the PMs identified by HSD to evaluate the accuracy of the PMs reported by, or on behalf of, an MCO or SE. The validation also determined the extent to which Medicaid-specific PMs calculated by an MCO or SE followed specifications established by HSD.
   c. Validation of Performance Improvement Projects (PIPs): The EQRO reviewed two PIPs for each MCO Medicaid program and the SE to verify that the projects were designed, conducted, and reported in a methodologically sound manner. For the PH MCOs with Salud! and State Coverage Insurance (SCI) programs, HealthInsight New Mexico reviewed two PIPs for the Salud! program and two PIPs for the SCI program.

This EQRO audits include the following information for each mandatory CMS activity conducted: activity objectives; technical method of data collection and analysis; description of data obtained; conclusions drawn from the data; and recommendations for improvement. An assessment of the SE's and each MCO's strengths and weaknesses and information to compare plan performance (as available) are included. When possible, findings from the most recent activities

are compared to results from previous time periods, and the status of improvement activities is discussed. Based on the available audit findings, recommendations for improving the quality of health care services provided by each MCO and SE are offered.

11) In addition to routine encounter data validation processes that take place at the MCO and State level, the State must maintain its contract with its EQRO to require the independent validation of encounter data for all MCOs at a minimum of once every three years. In addition, the State or its EQRO will monitor and annually evaluate the MCOs and/or their contracting providers' performance on the HCBS requirements under Centennial Care. These include but are not limited to the following:

    a) Level of care determinations – to ensure that approved instruments are being used and applied appropriately and as necessary, and to ensure that individuals being served with the Community Benefit have been assessed to meet the required level of care for those services.
    b) Service plans – to ensure that MCOs are appropriately creating and implementing service plans based on enrollee's identified needs.
    c) MCO credentialing and/or verification policies – to ensure that HCBS services are provided by qualified providers.
    d) Health and welfare of enrollees – to ensure that the MCO, on an ongoing basis, identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation. The state monitors the Critical incident database and MCO reports and follows up on reports of abuse, neglect, exploitation and ensures the notification of agencies. This is reported to CMS through the quarterly STC reports.

Additionally, an evaluation for nursing facility level of care (LOC) must be given to all applicants for whom there is a reasonable indication that services may be needed in the future either by the State, or as a contractual requirement by the MCO. The LOC process and instruments will be implemented as specified by the State. MCOs will use common elements within their tools that are based on the Minimum Data Set. The State will approve the evaluation

tool used by each MCO for this LOC determination and the MCO is responsible for informing HSD of the Member's eligibility and enrollment status. The State will assure that MCOs provide objective LOC determinations by: i. The use of LOC determination criteria developed by the state; ii. The State's QB and/or its EQRO will regularly conduct a review of a valid representative sample of each MCO's LOC determinations to assure that LOC criteria are being appropriately applied; iii. The State's QB and/or its EQRO will sample MCO LOC determinations to assure that LOC criteria are being appropriately applied by the MCOs; iv. The MCOs will report monthly on the LOC determinations/redeterminations they conduct; and v. Beneficiaries will have the opportunity to appeal determinations.

12) State advisory committees and MCO participant advisory committees will meet periodically to discuss issues. Meeting minutes will be kept and analyzed by the State to determine further action when required. CMS will have access to these minutes upon request.

Each MCO will submit for HSD approval, a delivery system improvement project that is designed to increase the use of electronic health records by its contract providers and to increase the number of its contract providers who participate in the exchange of electronic health information using the HIE operated by the NM Health Information Collaborative or its successor. The MCO's submission will include: a brief description of the project; a clearly stated goal that can be validated with data; a discussion of the base line from which the plan seeks to make progress and the data used to determine the base line; and a discussion about measuring progress toward the goal and the data used to measure progress. The MCO's plan will be submitted to HSD by February 1, 2014 and HSD will provide feedback/approval within two (2) weeks of receipt of the MCO's plan. The goal agreed to by the MCO and HSD will become the target for release of withhold associated with this objective.

VI. CONCLUSIONS AND OPPORTUNITIES

A. Successes

1. To improve the health and welfare for New Mexicans, the State has established the following:

   a. A Pay for Performance initiative, including a contract tracking measure, to improve immunization rates for NM children. The MCO and State multi-agency collaborative to improve immunization rates is continuing.

   b. A critical incident database has been established that enables providers to electronically enter reports related to abuse, neglect, exploitation, expected and unexpected deaths. The quality bureau analyzes these reports and takes appropriate action when warranted. The MCOs generate monthly reports that allow for identification of areas for improvement.

   c. Asthma Disease Management Programs developed by the SALUD! MCOs are reporting decreases in ER utilization and hospitalizations among members with asthma by providing member with tools for self-management.

   d. A tracking measure was implemented to monitor the prevalence of early screening for Developmental Delays. Recommendations call for standardized methods for identifying children at risk of developmental delays, easy access to services for children with identified delays, coordinated case management, and ongoing measurement to produce information to facilitate quality improvement. The state is currently partnering with Envision NM to influence primary and pediatric practices to include routine uniform screening for early developmental delays.

   e. Disparities in preventative dental care to the Developmentally Delayed population have been identified.

   f. Disparities in obtaining adequate prenatal care in regions of the state heavily populated by Native Americans have been identified.

2. Health Information Technology

   The New Mexico Health Care Providers E-Prescribing Project is a collaboration between HSD/MAD and the *HealthInsight* New Mexico (formerly New Mexico Medical Review Association or NMMRA). The project goal is to make e-prescribing widely available and to improve efficiency and reduce errors through the transmission of prescriptions from healthcare providers to pharmacists. Other benefits include formulary compliance, dosage compliance, detection of duplicate prescriptions, potential drug interactions, and medication history eligibility verification.

Salud! Members are currently benefiting from telemonitoring initiatives that have been initiated throughout the state. One such initiative is targeted to high-risk patients in home care settings. Principal participants include Presbyterian Home Health, *HealthInsight* New Mexico and the New Mexico Association for Home and Hospice Care. The project goal is to improve patient health through better management of chronic conditions and post-hospitalization care. Another telemonitoring initiative is the Envision New Mexico "Childhood Overweight Medical Management Telehealth Consultation (COMM-TC). This program links pediatric specialists from the University of New Mexico Health Science Center with rural, primary health care providers to provide instruction regarding the care of overweight children and their co-morbid conditions.

3. The New Mexico **"Web Portal"** extends the business capabilities of Medicaid program providers by offering user-friendly tools and resources electronically. Registered users may log in to access the following interactive features of the portal:

    a. Claim status inquiry;
    b. Prior authorization inquiry;
    c. Eligibility inquiry;
    d. Payment history inquiry; and
    e. Reports and data files.

4. Health Insurance Exchange

    In a news release issued by the U.S. Health and Human Services Department on January 3, 2013, it stated that New Mexico has made significant progress, and will be ready in ten months for open enrollment when New Mexicans will be able to use the new marketplace to easily purchase quality health insurance plans.

    Because of the Affordable Care Act, consumers will have access to a new marketplace starting in 2014 where they can access quality, affordable private health insurance. These comprehensive health plans will ensure consumers have the same kinds of insurance choices as members of Congress.

    Consumers in every state will be able to buy insurance from qualified health plans directly through these marketplaces and may be eligible for tax credits to help pay for their health insurance.

B. Challenges

1. Challenges with data collection include:
   a. Constantly changing requirements at the State and Federal level.
   b. Frequency of encounter data submissions.
   c. Deadlines for regular/ongoing encounters data submissions.
   d. Data accuracy verification.
   e. Data validation and completeness edits and analysis.
   f. Benchmarks and norms for comparison.
   g. TPL information completeness.
   h. 1099s – What interfaces or actions needed between NM SLR and MMIS (both Xerox) to issue 1099s to individual providers who assigned their payments to their group practice or clinic and the payment was made directly to the group practice or clinic.
   i. Automated payments (vs. ATRs) for the EHR Program

2. The HSD IT staff is working diligently to address these issues.

VII. SUMMARY AND RECOMMENDATIONS

The State of New Mexico is embarking on an ambitious road leading to a new way of providing healthcare to the Medicaid and Medicare dually eligible populations. With the State's experience with managed care, Centennial Care is a natural extension for the future. The goals and objectives of Centennial Care will be realized through, in part, the quality improvement program. Through adequate capacity and services, coordination and continuity of care, appropriate and objective health risk assessments, notably for those Members with co-morbid, mental health conditions, excellent coverage and timely authorization of services, improvements and interventions utilizing best practices and innovations, New Mexico will see healthier New Mexicans.

Reporting, analyzing data, monitoring adherence to contract requirements and to federal and State regulations, continual review of applicable standards and national/regional trends, as well as providing feedback to the MCOs will mitigate fragmentation of services and improve care without reduction of services and promote better utilization of precious resources. The grant to implement the new PRISM II system will greatly facilitate our ability to analyze outcome measures for fifteen of the adult initial core set of performance measures.

To reach our vision for Centennial Care, we would recommend a focus on measuring, reporting and reducing disparities in care as well as measuring and improving coordination of care across settings, providers and domains (dental, medical and behavioral).