Centennial Care Waiver Demonstration

Section 1115 Annual Report
Demonstration Year: 2 (1/1/2015 – 12/31/2015)

April 1, 2016

New Mexico Human Services Department

Section I: Introduction

Launched on January 1, 2014, Centennial Care places New Mexico among the leading states in the design and delivery of a modern, efficient Medicaid program. Approximately 640,000 members are enrolled in the program. During the past two years, Centennial Care has focused on improving the delivery of care for New Mexicans through better care integration with its robust care coordination program and emphasis on patient-centered care; increasing provider capacity by maximizing scopes of practice for certain providers, expansion of telehealth services and increased use of community health workers; and advancing payment reform initiatives that engage providers to move away from volume-based billing toward a model of care that aligns payment with enhanced performance and improved quality outcomes.

Some highlights from the second year of the program include:

A. Emphasizing Patient-Centered Care

- Completed health risk assessments for 70 percent of members;
- More than 70,000 members in higher levels of care coordination;
- More than 200,000 members receiving care in patient-centered medical homes;
- More than 21,000 members receiving home and community benefits;
- 500 high need/high cost members served in a program administered by the University of New Mexico, ECHO Care, that provides access to an intensivist team, which includes primary care physicians, behavioral health counselors, specialists as needed, and community health workers.

B. **Supporting Provider Capacity**

- Continuation of the Primary Care Physician Enhanced Rate—1,982 providers receiving increased payments;
- Maximizing Scopes of Practice for Certain Providers;
- MCOs expanding use of telehealth office visits and launching virtual physician visits, including with behavioral health providers; and
- Increasing Use of Community Health Workers:
  - CHWs work with high ED utilizers to redirect them to PCPs, educate about healthy behavior, disease management and community resources;
  - More than 100 directly employed by or contracted with MCOs;
  - FQHCs actively engaging CHWs, including PMS, HMS and First Choice;
  - MCOs partnering with UNM to expand role of CHWs—care coordination, health education, health literacy, translation and community supports linkages;
  - 2015 Delivery System Improvement Target requires MCOs to increase utilization of CHWs.

C. Implementing Payment Reform Projects

HSD approved 10 payment reform projects in early 2015; all projects launched in July 2015, including:

- Accountable Care Like Models—performance-based model with partial payment paid as bonus for achieving quality outcomes;
- Bundled Payments for Episodes of Care—bariatric surgery, diabetes and maternity;

- Patient-Centered Medical Home Shared Savings—built upon PCMH model by adding shared savings targets that reward achievement of utilization and quality targets.

Member Rewards Program

- 458,876 total participants (65% of enrollees) are actively participating in Centennial Care member rewards program that offers rewards for engaging in healthy behaviors. Early results for the program include:
  - Inpatient admissions reduced for diabetes (52%) and asthma (31%) while "high-value" services such as PCP visits and prescription medications increased;
  - Compliance with diabetes quality measures (e.g., HEDIS measures) increased for participants from 24% to 43%; and
  - Compliance with quality measures for participants with asthma increased up to 47%.

D. Medicaid Expansion and the Affordable Care Act

At the end of 2015, 235,000 New Mexicans were enrolled in the Medicaid expansion program for adults. Most of the low-income adults who are eligible for the expanded Medicaid program receive their health care benefits through the Alternative Benefit Plan (ABP). The ABP includes doctor visits, preventive care, hospital care, emergency room and urgent care, mental health care and treatment for substance use, prescriptions and other services that are defined as "essential health benefits" by the Patient Protection and Affordable Care Act (ACA). In addition, the Medicaid adult dental benefit is included in the ABP.

Section II: Summary of Quarterly Report - Operational Issues

A. Annual Budget Neutrality Monitoring Spreadsheet

The annual budget neutrality monitoring spreadsheet for waiver year two is included in this report as Attachment A.

B. Health Care Delivery System Update

1. Benefits

There were no changes in Medicaid covered services or benefits during DY2. In addition to Medicaid covered services, the MCOs are permitted to provide value added services (VAS) to their members, which must be approved in writing by HSD. Value Added Services are additional services covered by the MCOs which may fall within any of the Centennial Care program services areas, physical health, behavioral health and/or long term services and supports. MCOs may also offer VAS to members who receive the alternative benefit plan (ABP). Services vary by MCO and are outlined in Attachment B and C, Value Added Services 2015 and 2016.

2. Enrollment

Centennial Care enrollment has continued to increase each quarter during the second waiver year. Expansion of Medicaid eligibility has greatly contributed to the increase in enrollment. The majority of Centennial Care members are enrolled in Population 1-TANF with Related. Population 6-Group VIII (expansion) is the next largest group.

3. Disenrollment

HSD continues to monitor disenrollment and any potential issues. Validation checks are run periodically to identify any possible concerns. Any issues that are identified or reported are researched and addressed. Overall, disenrollment continues to decrease.

4. Grievances and Appeals

A total of 4,385 grievances were filed by all Centennial Care members in the second waiver year. Member grievances were tracked quarterly for each MCO by reports per 1000 enrolled members.

Table #1 – Member Grievances

WY2	Grievances per 1000 Enrolled Members			
Quarter	**BCBSNM**	**MHP**	**PHP**	**UHC**
Q1	1.68	.24	1.42	4.55
Q2	1.46	.16	1.29	3.61
Q3	1.26	3.14	1.63	3.53
Q4	1.12	2.69	1.39	3.11

MCOs reported a combined total of 2,166 grievances within the top four types of grievances. The top four types of grievance categories reported were:

1. Ground transportation non-emergency
2. Primary Care Physician
3. Other Specialists
4. Emergency Room

Issues with non-emergency ground transportation grievances represented the largest number of grievances reported. Transportation concerns included late and/or no pick-ups for scheduled appointments or return trips, rude drivers/staff and unsafe driving by drivers. Issues with Primary Care Physician include billing concerns, prescription issues and appointment availability. Other Specialties issues include dissatisfaction with provider, billing, and Emergency Room issues include the quality of services received by members.

MCOs responded to the concerns of transportation by working closely with their transportation vendors and by implementing action plans as needed. For PCP billing concerns, the MCO Provider Advocates target the top three providers per month in order to train and educate regarding billing policy. Each MCO investigates Emergency Room issues internally to assist in improving the quality of services members receive.

The remaining types of grievances constituted less than four percent of any individual type reported. No additional trends have been identified in any of these other areas.

Table 2 below illustrates the additional types of grievances reported by MCO within the top three types.

Table # 2 – Types of Grievances

Grievance Type	Number Reported	Percentage Reported
Ground Transportation Non-Emergency	1241	27.69%
Primary Care Physician	428	9.67%
Other Specialties	301	6.86%
Emergency Room	223	5.09%

Member Appeals

A total of 5,435 appeals were filed by members of all MCOs in DY2. Of the total appeals filed, 2,459 (45 percent) were upheld, 982 (18 percent) were overturned, 1,813 (33 percent) were still pending resolution at the end of the year. All MCOs have processed appeals in a timely manner.

The MCOs reported 4,099 (75 percent) of the total member appeals were due to denial or limited authorization of a requested service and the second highest reason for member appeals was a reduction of a previously authorized service at 756 total member appeals (14 percent.) All other reasons for appeals constitute 580 (11 percent) of the total number of appeals filed by members. No other specific trends were identified. All MCOs have processed appeals in a timely manner.

5. Quality of Care

Please refer to Section II. B. for information related to quality of care.

6. Access

Throughout this report, unless otherwise noted, the most current monthly data available is through November 2015. Quarterly data is available through the third quarter of 2015.

All MCOs were far below the primary care provider (PCP)-to-member contractually required ratio of 1:2000 in DY2. The ratios ranged from 1:17 to 1:109 as reported by the MCOs in the third quarter. The PCP-to-member ratio is calculated as of the last day of the reporting period and by dividing the total number of non-dual members by the total number of PCPs. Dually-eligible members are excluded from the calculation, because a dually-eligible member has a PCP through Medicare. Open PCP panel slots for new patients range from 83 – 99% depending on the MCO. There were not any identified PCP ratio concerns in 2015.

Geographic access requirements for hospitals, primary care physicians, pharmacies, dentists and most specialty providers were met in urban, rural and frontier counties. A statewide enrollment challenge continues for all MCOs in the area of dermatology. In some instances, the population and the number of residents requiring specialty services may not be sufficient for a provider to establish and/or sustain a specialty practice, and some MCOs recruit out-of-state border area specialists to help fill gaps. The MCOs utilize non-emergency transportation with meals and lodging as necessary, telemedicine, and single case agreements to ensure that the members who require medically necessary services receive them. Please also see Section V. A. for details on telemedicine in the Delivery System Improvement Fund.

MCOs continue their efforts to recruit and contract with new providers as well as focus on retention and provider satisfaction. HSD monitors member reporting about access as

reported in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The MCO Grievances and Appeals reports are also monitored and evaluated regarding reporting of access concerns.

Billing for Non-Independently Licensed Clinicians

In response to the need for additional clinicians in the behavioral health (BH) network, HSD implemented in DY2 a process by which existing New Mexico Behavioral Health Agencies may request certification for status as an agency that can provide clinical supervision to and bill for non-independently licensed clinicians. When certification is granted, the non-independently licensed clinicians at that agency will then be able to provide supervised clinical services that were not previously available due to level of licensure.

Since implementation on October 1, 2015, thirty-three BH agencies were identified as being approved under the previous Statewide Entity's Supervisory Protocol (OptumHealth Supervisory Protocol) and are able to provide clinical supervision to and bill for behavioral health services provided by non-licensed clinicians. Forty-nine unique behavioral health providers and/or behavioral health agencies have requested information. Eighteen of the providers who inquired about the certification were not eligible. One applicant agency has received full certification status and another has received provisional certification status to provide supervision to non-independently licensed clinicians and to bill for services those individuals provide. HSD is following up with the other twenty-nine behavioral health agencies that are in various stages of the certification process. HSD is implementing monthly technical assistance calls with behavioral health agencies that are requesting certification status.

HSD is actively working with other state and regulatory agencies to promulgate changes to NMAC 8.321.2.9 to allow BH agencies (type 432) to provide clinical supervision to and bill for BH services provided by supervised non-licensed clinicians.

Transportation

By DY2 Q2, all MCOs met geographic access standards for non-emergent ground transportation in urban, rural and frontier areas. HSD had provided clarification to the MCOs to include provider fleet locations in addition to provider home offices. In DY2, HSD conducted a full analysis of non-emergent transportation services system-wide using a "per 1,000 trips" rate. While the number of grievances per 1,000 trips was determined to be relatively low, HSD recognized that missed medical appointments and/or inadequate service provision by non-emergent transportation vendor(s) has the potential to adversely affect the health, welfare and/or safety of Centennial Care members. HSD provided the MCOs with several recommendations to be addressed in a collaborative workgroup, MCO Transportation Workgroup. The MCOs met; developed a work plan; and, established that each MCO had an annual evaluation for its non-

emergent transportation vendor. In DY2, the MCOs collectively proposed Severity Tier Levels for non-emergent transportation member complaints and recommended placement of the codes and tiers within the resolution column of the MCO Grievances and Appeals Report. The MCO submissions, as a result of the workgroup, are currently being evaluated by HSD.

7. Other

Dental

Analysis of 2015 MCO reports show that the preventive services are in the top ten dental services based on number of paid claims for both children and adults. According to the CDC, preventive dental interventions, including early and routine care, fluoridation, sealants and other preventive care are cost-effective in reducing disease burden and associated expenditures. Preventive care may also reduce the need for costly emergency room visits for exacerbated dental conditions.

Pharmacy

Each MCO has a Pharmacy and Therapeutics (P & T) committee which evaluates, reviews, and provides guidance and clinical recommendations. These reviews and evaluations are based on product information, supporting clinical and economic information, an impact model, clinical value, overall cost and any additional supporting information. HSD attentively follows the MCOs' P & T reviews and adoption of new pharmaceuticals.

During DY2, the MCOs reported an increase in utilization of high-cost specialty pharmacy products to treat diabetes and the hepatitis C virus (HCV). HSD initiated a quarterly HCV Workgroup with all MCOs participating. As noted in DY2 Q4, a Letter of Direction (LOD) was issued in November that provided new treatment guidelines and a Uniform New Mexico HCV Checklist for Centennial Care. HSD also directs MCOs to contact members (and providers) who now meet the treatment criteria, but were previously denied treatment, for reconsideration of their HCV treatment requests. The increase in the number of cases treated from 2014 to 2015 went from 164 to 491, a 199% increase, which is significant. HSD will be tracking and trending utilization of treatment and prior authorization outcomes with MCO monthly reports. The HCV Workgroup will also review the current data and recent guidance revisions and may propose future evidence-based revisions to the treatment guidelines.

All MCOs provide generic medications when available. There are no identified concerns at this time regarding over-utilization of brand name medications.

The total annual data through November 2015 reflects an overall denial percentage of 21% for the program. UnitedHealthcare (UHC) and Molina Health Care of New Mexico (MHNM) have the highest denial rates of 25.3% and 23.1% respectively. Blue Cross

Blue Shield of New Mexico (BCBSNM) and Presbyterian Health Plan (PHP) denial rates are both 18.1%. Denial reasons tend to be front-end edits as reported in DY2 quarterly reports and are mainly due to pharmacy adjudication errors and medication utilization or over-utilization edits. Pharmacy claims processed may be denied with front-end edits to determine if the claim(s) meet basic requirements of HIPAA standards, then edits post based on the plan requirements. HSD will continue to monitor denial trends and address any concerns as needed.

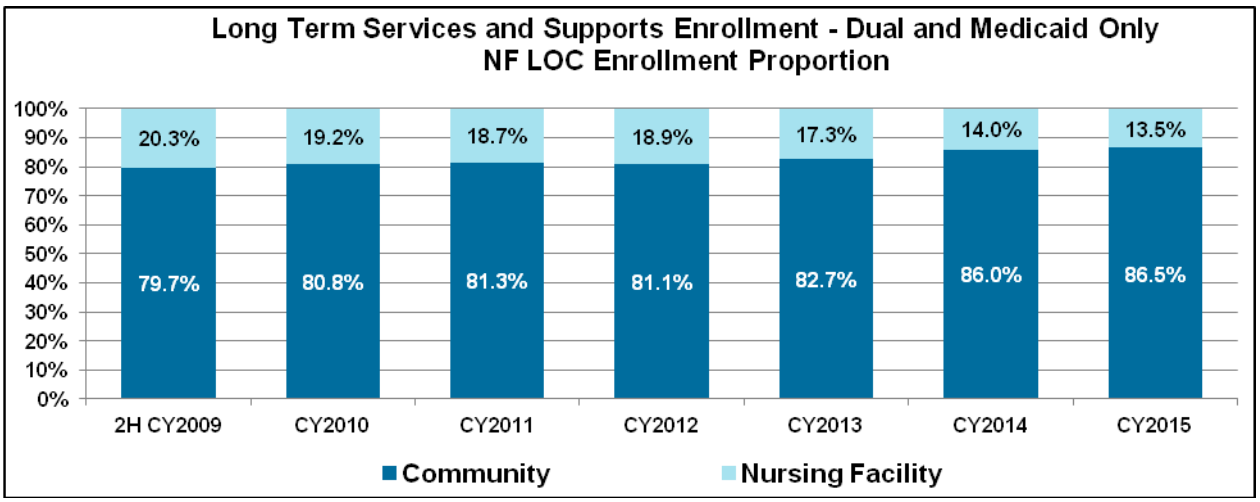
Nursing Facilities (NFs)

Effective July 1, 2015, nursing facilities (NFs) received an appropriation to increase the "low NF" rate. NF level-of care (LOC) decisions are based solely on utilization review requirements and supported by documentation.

Continuing to Serve the Long-Term Care Population in the Community

- Centennial Care removed the requirement to need a waiver slot in order to access the community benefit.
- Centennial Care continues to have a positive impact on the proportion of members residing in the community vs in Nursing Facilities.

Table #3 – Long Term Services & Supports



Contract Amendments

There was one amendment to the Centennial Care MCO contracts in DY2. Please see Attachment D – Centennial Care Contract Amendment #4.

Community Interveners

In DY2, seven Centennial Care members received Community Intervenor services. Community Outreach Program for the Deaf (COPD) provided training to BCBS care coordinators to educate them on how to identify members who may be eligible for the Community Intervener service.

Table #4 – Consumers and Community Intervener Utilization

MCOs	# of Consumers	Total # of CI Hours Provided	Claims Billed Amount
BlueCross/Blue Shield	3	116.76	$2,920.75
Molina	0	0	$0
United Healthcare	3	156.75	$3,918.75
Presbyterian	1	362.50	$362.50
Totals	7	636.01	$7,202.00

Care Coordination

In July 2014, HSD directed all four MCOs to initiate unique and innovative campaigns in order to connect with their unreachable members in need of completing a health risk assessment (HRA) and/or a comprehensive needs assessment (CNA). A member is defined as unreachable after a minimum of three attempts have been made to contact the member and a follow up letter has been sent to the member's address of record. A baseline of unreachable members was established and updated each month, and the MCOs were required to reduce their unreachable members by a minimum of 10% by October 1, 2014 and 5% per month thereafter. Each MCO met the October 2014 goal, and the MCOs continued their efforts through 2015.

In order to measure the effectiveness of the campaign, a baseline is established each month removing members who have been reached during the month and either completed an assessment, declined an assessment, or who have been dis-enrolled. New members are added to the baseline. When comparing the January 2015 baseline for all MCOs to the ending baseline in December 2015, the MCOs collectively reduced the net percentage of unreachable members by 43% (146,964 unreachable members to 84,381 unreachable members). When considering all of the members who had been reached at the end of each month, rather than the change in the baseline from January to December, over 136,000 unreachable members had eventually been reached by the MCOs during DY2.

As stated in the DY2 Q4 report, HSD identified an additional member group not defined in the contract, or otherwise predicted by the program, as the member who is "difficult to engage" (DTE). The DTE member is a member who has been reached but has not followed through with completing an HRA or has declined the assessment at the time of contact. Based on data observations to date, HSD predicts that while unreachable member

rates are likely to remain stable, the number of DTE members, and members who decline an HRA, are likely to increase. This is because healthy members in care coordination level 1 (CCL1) may not want to repeat annual HRAs year after year. It is important to note that members who are determined to be unreachable, who are DTE, or who have declined an HRA, do not lose Medicaid eligibility as a result of not completing an HRA.

Electronic Visit Verification (EVV)
Statewide implementation of EVV has been slower than anticipated due to a large number of providers in more remote geographic areas that have limited technological capacity. However, approximately 49% of providers are using the system. HSD and the MCOs are continuing to explore additional or alternative technologies for a solution that will improve the percentage of Personal Care Service (PCS) providers who are able to utilize the EVV system.

Health Plan Contract Compliance and Financial Performance Relevant to the Demonstration
In DY2, HSD implemented sanctions primarily related to untimely and inaccurate report submissions as defined in its agreement with the MCOs. In contract amendment #4, HSD further defined the penalties for non-compliance with the contract. See Attachment D – Centennial Care Contract Amendment #4.

Self-Directed Community Benefit (SDCB)
In DY2, HSD continued to work on finalizing the HCBS State-Wide Transition Plan which includes community integration requirements for residential and non-residential settings as outlined in the CMS final rule.

C. Adverse Incidents

HSD continues to work with the Critical Incident (CI) workgroup to deliver Behavioral Health (BH) protocols to providers. The BH protocols will be used by BH providers to improve accuracy of information reported and to establish guidelines for the type of BH providers required to report.

CIs are being reported quarterly by each Managed Care Organization (MCO). This data is trended and analyzed by HSD.

The HSD CI Unit engaged in the following monitoring activities during CY 2015 with respect to the performance oversight of the MCOs and their provider agencies:

- The CI workgroup meetings continued to be held monthly until September. At that time, the MCOs and HSD agreed that CI workgroup meetings had reached a level of confidence with the issues and concerns about the critical incident reporting process that the meetings would be held bi-monthly.
- In an effort to provide technical assistance to MCOs and overcome issues of incorrect reporting, inadequate information or requests for specific follow-up with egregious

situations, CI reporting procedures were developed for the following topics: the definition of natural death vs expected death; MCO eligibility verification; reporting abuse, neglect and exploitation to Adult Protective Services/Child Protective Services; verification of Nursing Facility Level of Care (NFLOC); duplicate reports; and high utilization of Emergency Room (ER).

- A written protocol was delivered by HSD to provide the MCOs with a framework to direct their providers in BH reporting. During this calendar year, the MCOs trained their Personal Care Service (PCS) and BH providers on BH CI reporting and the implementation of the protocols in Albuquerque, Roswell, Las Cruces, Farmington and Santa Fe. Each of the five (5) trainings identified training supports for caregivers of members who live with mental illness in an effort to continue enhanced delivery of HCBS and outcomes for these members.
- Daily review of incident reports is conducted by the MCOs and the HSD CI unit. HSD continues to direct the MCOs to provide technical assistance when providers are non-compliant. The CI unit has continued the initiative for the weekly aggregated reports of concerns by sending the concerns list to the MCO contract manager at HSD. The contract manager then sends the concerns list to the appropriate MCO with an established deadline for follow-up. This includes the quality compliance team and upper management of each MCO, ensuring that the quality of reporting by providers and the documentation of follow-up is met timely. The MCOs respond with sufficient information to assure HSD that the MCOs and agencies are addressing the concerns. The process has continued to improve performance and timeliness.
- Internal collaborations continue to occur between the HSD CI Unit and other internal HSD staff. The HSD CI Unit shares information with HSD Care Coordination staff for follow through when a concern is identified with MCO care coordination.

During CY 2015, a total of 12,180 Critical Incidents reports were filed. A 100% review of all deaths submitted through the HSD CI web portal is conducted. HSD clinical staff reviews and consults on mortality cases, quality of care and complex cases**.**

Throughout 2015, a total of 1,433 deaths were reported. Of those deaths:

- One thousand two hundred forty-six (1,246) deaths were expected/natural deaths.
- One hundred and sixty nine (169) were unexpected deaths; all were investigated and closed. Of the 169 unexpected deaths, one hundred thirty-nine (139) did not occur during authorized services hours and thirty (30) unexpected deaths did occur during authorized services hours. At the time the MCO reports unexpected deaths, an internal review is done and law enforcement is contacted. These critical incidents remain under review until the MCO receive results of their review either from their internal review, law enforcement, or the Office of the Medical Investigator.

- Five (5) were homicides; one occurred during authorized service hours. The five homicides are pending investigation by the MCO, and/or results from the Office of the Medical Investigator at the end of the year.
- Thirteen (13) deaths were suicides and did not occur during authorized services hours or in a facility.

Throughout 2015, a total of one hundred sixty one (161) cases of missing/elopement were reported. Law enforcement was notified in all cases and protocols were followed. Of those missing/elopement:

- One hundred and fifteen (115) cases of missing/elopement were reported by home health agencies providing Home and Community Based Services (HCBS) for member's ages 10-85; four (4) cases of missing/elopement occurred in ages 10-19; one hundred eleven (111) cases occurred in ages 22-85. These HCBS members were reported missing by their families, or were not found at the time of their authorized service hours.
- Forty six (46) cases of missing/elopement were reported by Behavioral Health Provider agencies; ten (10) were reported by Treatment Foster Care through ages 14-19; eleven (11) reported by outpatient behavioral health agencies ages 13-66; twenty (20) cases of missing/elopement were reported by non-accredited residential treatment centers for ages 16-51; five (5) cases reported by accredited residential treatments centers 12-17.

Table #5 – Critical Incidents

Critical Incident Types (BH, Self-Directed, and Fee for Service	Centennial Care		Critical Incident Types	Behavioral		Critical Incident Types	Self-Directed	
	#	%		#	%		#	%
Abuse	875	7%	**Abuse**	223	2%	**Abuse**	44	8%
Death	{1433}		**Death**	{54}		**Death**	{48}	
Natural/Expected	1246	10%	Natural/Expected	30	3%	Natural/Expected	43	8%
Unexpected	169	1%	Unexpected	21	2%	Unexpected	4	1%
Homicide	5	0%	Homicide	1	0%	Homicide	0	0%
Suicide	13	0%	Suicide	2	0%	Suicide	1	0%
Emergency Services	7329	60%	**Emergency**	496	47%	**Emergency**	354	66%
Environmental Hazard	208	2%	**Environmental**	0	0%	**Environmental**	8	1%
Exploitation	441	4%	**Exploitation**	14	1%	**Exploitation**	34	6%
Law Enforcement	511	4%	**Law Enforcement**	143	14%	**Law Enforcement**	24	4%
Medication/Treatment Error (BH	10	0%	**Medication/Treat**	8	1%	**Medication/Treat**	0	0%
Missing/Elopment	161	1%	**Missing/Elopmen**	46	4%	**Missing/Elopmen**	7	1%
Neglect	1212	10%	**Neglect**	68	6%	**Neglect**	15	3%
Total	**12180**		**Total**	**1052**		**Total**	**534**	

Per CMS's request, HSD has broken out critical incidents by MCO and included the non-Centennial Care (fee-for-service) data in the table below.

Table #6 – Critical Incidents by MCO

Critical Incident Types by MCO (BH, Self-Directed, and Fee for Service- Centennial Care										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		FFS/HSD	
	#	%	#	%	#	%	#	%	#	%
Abuse	105	5%	261	8%	209	11%	300	6%	1	17%
Death	328	16%	420	13%	206	11%	478	10%	1	16%
Emergency Services	1273	62%	1,829	56%	1,097	56%	3127	67%	2	33%
Environmental Hazard	24	1%	55	2%	40	2%	89	2%	0	0%
Exploitation	75	4%	121	4%	60	3%	185	4%	0	0%
Law Enforcement	73	4%	194	6%	120	6%	123	3%	1	16%
Medication/Treatment Error (BH	1	0%	3	0%	3	0%	3	0%	0	0%
Missing/Elopement	27	1%	62	2%	35	2%	37	1%	0	0%
Neglect	157	8%	313	10%	177	9%	564	11%	1	16%
Total	2063		3,258		1,947		4906		6	

D. Action Plans

MCOs were effective in reducing the number of actions plans required to ensure contract compliance from 44 in DY1 to 7 plans in DY2. A total of six action plans were active at DY2 year end. Two of the plans remained open for monitoring purposes. MCOs are actively making progress on the remaining four plans and have established baselines, goals and timelines. The four action plans include: non-emergent transportation grievances, regulatory reports, behavioral health, and environmental modifications. Please refer to DY2 Q4 Attachment D – MCO Action Plans, for descriptions and current status of each plan. In the case of non-emergent transportation, MCOs collaborated in a Transportation Workgroup to identify and establish severity indicators for missed appointments due to late arrivals and no shows. By having these severity indicators in place, HSD will be able to better monitor the impact on members, and the MCOs will be able to respond appropriately to ensure quality and continuity of care.

E. Evaluation Activities

During waiver year two, progress under the work plan continued. The Deloitte Team worked with HSD to identify the various data elements needed to conduct the evaluation. In addition, Deloitte continued to develop the Evaluation Model incorporating both the pre-Centennial Care Baseline (without-waiver) and the Centennial Care (with-waiver) measures.

- Deloitte and HSD staff participated in weekly progress checkpoint calls to discuss data issues and resolve outstanding issues.
- Deloitte received the data needed to complete the first year evaluation for 111 of the 125 measures under review. Deloitte has developed Baseline calculations for 98% of the measures.
- Deloitte met with HSD staff in October 2015 to discuss the structure of the Annual Report, including the format of the tables and exhibits to be included.
- During January 2015, Deloitte worked on compiling the reports and evaluation model into the Annual Report

- Deloitte met with HSD staff in February 2015 to share and discuss the draft Annual report. The final draft Annual report is due to HSD on April 8, 2016.

F. Quality Assurance Monitoring Activities

1. Care Coordination

HSD conducted a desk audit in November 2015 of the MCOs' care coordination activities by a combined team of staff from MAD and BHSD. The audit evaluated the MCOs' adherence to contractual obligations related to care coordination delivery and the efficiency of additional training that was provided to their care coordination teams.

Based on previous audits conducted in 2014, the MCOs showed improvements in fundamental contract compliances such as timely completion of Comprehensive Needs Assessment (CNA) and documentation of falls. There was also improvement in note templates, supplemental CNA notes and efforts to contact and engage members.

While improvements were identified, the MCOs will need to continue to implement procedures in the areas of; addressing potential BH needs, back-up and disaster plan development; and ensure that updates to assessment records are clearly documented as updates; as these were findings noted in previous audits. HSD will continue to work with the MCOs to facilitate continued improvements to care coordination processes and procedures as well as continue to monitor the MCOs' progress, conduct audits, and provide feedback.

2. Service Plans

HSD continues to randomly review service plans to ensure that the MCOs are using the correct tools and processes to create service plans. The review of service plans also ensures that the MCOs are appropriately allocating time and implementing the services identified in the member's comprehensive needs assessment, and that the member's goals are identified in the care plan. Calendar Year 2015 did not identify any concerns.

Table #7 – 2015 Service Plan Audit

Service Plans	Quarter 1 2015	Quarter 2 2015	Quarter 3 2015	Quarter 4 2015	CY 15 Totals
Member files audited	120	120	120	120	480
Percent of service plans with personalized goals matching identified needs	100%	100%	100%	100%	100%
Percent of service plans that hours allocated matched need	100%	100 %	100%	100%	100%

3. Nursing Facility Level of Care (NF LOC)

HSD continues to review high NF LOC and community benefit NF LOC denials on a quarterly basis to ensure the denials were appropriate and based on NF LOC criteria.

Table #8 – 2015 NF LOC Audit

	Quarter 1 2015	Quarter 2 2015	Quarter 3 2015	Quarter 4 2015	CY 15 Totals
High NF denied requests (and downgraded to Low NF)					
# of member files audited	14	15	14	16	59
# of member files that met the appropriate level of care criteria	14	15	14	16	59
% of MCO level of care determination accuracy	100%	100%	100%	100%	100%

	Quarter 1 2015	Quarter 2 2015	Quarter 3 2015	Quarter 4 2015	CY 15 Totals
Community Benefit denied requests					
Number of member files audited	16	15	16	14	61
Number of member files that met the appropriate level of care criteria	16	15	15	14	60
Percent of MCO level of care determination accuracy	100%	100%	94%	100%	98%

G. Post Award Forum

The Centennial Care post award forum was held on Monday, November 23, 2015 as part of a regular Medicaid Advisory Committee (MAC) meeting where meaningful comments about the progress of Medicaid's Centennial Care program since implementation. HSD will utilize the valuable information gained during the public forum from MAC members, Centennial Care members, advocates and providers, to assist in its continued efforts to improve services, healthcare outcomes and member satisfaction.

The public forum offered a broad range of comments, for example, from parents with autistic children navigating the eligibility process, Centennial Care member experiences using care coordination, concerns with behavioral health services in nursing homes, to requests for increasing provider reimbursement rates. However, some of the strongest comments offered came from advocates, providers and Centennial Care members regarding the assessment process and its impact on members using long-term services and supports (LTSS) in Agency Based Community Benefits (ABCB) and Self-Directed Community Benefits (SDCB).

HSD took steps prior to the MAC Public Forum to work with advocates, Centennial Care MCOs and members receiving LTSS to improve outcomes and member satisfaction. HSD participated in legislative hearings with public comments, coordinated with staff from MCOs, the Aging and Disability Resource Center (ADRC) and community organizations to add and improve provider trainings and provider engagement, and partnered with the New Mexico

Independent Consumer Support System (NMICSS) to conduct roundtable discussions with MCOs and members. But as a result of additional feedback provided at the MAC Public Forum, HSD took immediate steps to implement an internal Centennial Care Long-Term Care (LTC) workgroup with HSD and MCO staff to tackle the specific issues and concerns raised. A LTC Assessment and Allocation sub-committee was also formed to refine policy where applicable. HSD is working directly with the advocacy organization Disability Rights New Mexico (DRNM) and is seeking their input as the LTC workgroups provides recommendations.

Section III: Total Annual Expenditures

Table #9 – Waiver Year 2 Expenditures

Medicaid Eligibility Group (MEG)	Program Expenditures	Administrative Expenditures
MEG01 – TANF & Related	$ 1,588,211,731	$ 62,876,804
MEG02 – SSI & Related - Medicaid Only	$ 872,687,614	$ 7,189,906
MEG03 – SSI & Related - Dual Eligible	$ 578,398,116	$ 6,269,386
MEG04 – "217 Like" Medicaid Only	$ 5,804,002	$ 36,934
MEG06 – "217 Like" Dual Eligible	$ 84,706,744	$ 391,394
MEG06 – VIII Group – Medicaid Expansion	$ 1,497,131,414	$ 40,750,848
MEG07 – CHIP	$ 119,312,247	$ 9,326,999
MEG08 – Uncompensated Care Pool	$ 0	N/A
MEG09 – Hospital Quality Improvement Incentive Pool	$ 2,824,462	N/A
Grand Total	$ 4,749,076,330	$ 126,841,271

Source: New Mexico CMS 64 Submissions, FFY15 Quarter 2 through FFY16 Quarter 1

Section IV: Yearly Enrollment Report

Table #10 – Waiver Year 2 Enrollment

Demonstration Population		
	WY2 Member Months (as of 1/20/16)	WY2 Enrollment (as of 1/20/16)
Population 1 – TANF and Related	1,109,669	355,192
Population 2 – SSI and Related – Medicaid Only	124,213	42,672
Population 3 – SSI and Related – Dual	107,499	39,481
Population 4 – 217-like Group – Medicaid Only	533	276
Population 5 – 217-like Group – Dual	6,799	2,613
Population 6 – VIII Group (expansion)	713,358	306,183
Totals	2,062,013	746,417

Note: This data was extracted on January 20, 2016. Due to retro-active eligibility, member months continue to increase slightly after the end of the waiver year.

Additional detail on enrollment and disenrollment in demonstration year two is included in the fourth quarter report that was submitted to CMS on March 1, 2016.

Section V: Managed Care Delivery System

A. Accomplishments

1. Centennial Care Improvements

- HSD worked collaboratively with MCOs in 2015 to ensure uniformity in care coordination metrics within the Centennial Care Statistics Report.
- HSD initiated several workgroups to ensure effective service delivery and collaboration among stakeholders: Standardized Health Risk Assessment Workgroup, HCV Workgroup, Administrative Burden Reduction Workgroup, Long-Term Care Assessment Workgroup, Health Home Workgroups and Steering Committee, Transportation Workgroup (MCOs only), and ED Reduction Workgroup.
- Through HSD's initiated Unreachable Member Campaign, MCOs successfully reduced the number of unreachable members by a net 43% reduction in DY2. The total number of unreachable members decreased from 146,961 to 84,381.

2. Standardized Health Risk Assessment (HRA)

In DY2, HSD worked collaboratively with clinical representatives from the MCOs to develop a standardized HRA that incorporated contractually required elements. The standardized HRA will ensure that members are equally assessed across all four MCOs. The new HRA will be implemented in DY3.

3. HCV Workgroup

New treatment guidelines for chronic Hepatitis C virus (HCV) infection and a revised Uniform New Mexico HCV Checklist were implemented by each MCO to ensure that members are receiving treatment.

4. *Administrative Burden Reduction*

HSD is committed to reducing administrative burden for providers so that they may better focus their efforts on delivering high-quality healthcare. While not a specific component of the waiver, HSD continues to build requirements in its contract with the MCOs for administrative burden reduction. The Administrative Burden Reduction Workgroup (ABRW) meets monthly; the Credentialing Subcommittee and BH Subcommittee, offshoots of the ABRW, meet every two months.

HSD works with the New Mexico Hospital Association, New Mexico Association of Home and Hospice Care, the Nursing Facility Association, the Behavioral Health Provider Association and other provider associations and groups to identify areas of concern for providers. The ABRW identifies and responds to issues by streamlining processes, where possible, and facilitating provider trainings that will make the most impact in reducing administrative burden. Two significant accomplishments in DY2 were finalizing the behavioral health level of care criteria, and the credentialing

application. The standardized, credentialing application will be implemented in DY3 Q1.

Also in DY2, the ABR Workgroup requested a list of providers' top five concerns from the various associations and groups. A significant component of the ABRW's work is identifying those issues to address that will have the greatest improvements for providers while also attending to the unique needs of the various provider groups. Areas of focus in DY3 will include: working with MCOs to improve claims payment turnaround times for hospital claims; establishing a timeframe in which MCOs must load providers into their systems following credentialing; and, streamlining clinical documentation for submission to, and working to eliminate duplicative requests from, the MCOs. MCOs will also provide a joint billing training to Nursing Facilities. The ABRW will discuss establishing sub-committees in order to further focus workgroup activities in addressing the specific needs of provider groups and specialties. A provider training on crossover claims, provided by HSD, is scheduled in DY3 Q1.

5. Long-Term Care (LTC) Workgroup

HSD created a LTC workgroup at the end of Calendar Year 2015, to refine its long-term services and supports (LTSS) initiatives. The workgroup consists of representatives from each MCO, HSD management, and other stakeholders. Some initiatives include reviewing existing assessment tools to determine appropriateness, ensuring members are educated about the community benefit (CB) when first enrolling into Centennial Care and ensuring newly enrolled members are informed about the option to self-direct their CB services.

6. Health Homes

HSD continued the development of the Health Home project named "CareLink NM" in 2015 with outreach and presentations in Curry and San Juan Counties. HSD held public town hall meetings and met with provider sites in San Juan County and Curry County, collaborated with the MCOs and the two interested Health Home provider sites to develop a standardized Health Home Comprehensive Needs Assessment and Comprehensive Care Plan. The CareLink NM policy manual was developed to assist in the administration of the Health Homes for all entities affiliated with CareLink NM. HSD initiated the CareLink NM steering committee, comprised of HSD and MCO staff to: provide oversight of the Health Home provider; approve provider applications; perform readiness reviews; and perform the evaluation of the CareLink NM program. In 2015, HSD began the development of BHSDStar, a web-based data collection tool, to capture CareLink NM participant electronic health records. HSD plans to launch health homes in the Spring of 2016.

7. ***Delivery System Improvement Fund (DISF)***

The DSIF targets allow recognition of improvements with an emphasis on specific areas. HSD evaluated the MCO results for the 2015 DSIF targets. The four target areas were:

1. Increase the use of Community Health Workers (CHWs) for care coordination activities, health education, health literacy, translation and community support linkages in Rural, Frontier, and underserved communities in urban regions of the State.
2. A 15 percent increase in telemedicine "office" visits with specialist, including BH providers, for members in Rural and Frontier areas. At least 5% of the increase must be visits with BH providers.
3. A 5 percent increase in the number of members being served by Patient-Centered Medical Homes (PCMHs) or maintain a minimum of 40%.
4. A 10 percent reduction in per capita use of non-emergent emergency room use.

CHW results indicate that MCOs met the target. The MCOs provided clearly-stated goals and activities to substantiate an increased use of CHW for 2016. Telemedicine results indicate MCOs met the target. Blue Cross Blue Shield (BCBSNM) reported a 72.45 percent increase for physical health and 12.52 percent increase for behavioral health. Molina Heath Care (MHNM) reported a 48.7 percent increase for physical health and a 11.7 percent increase for behavioral health. Presbyterian Health Plan (PHP) reported a 25.21 percent increase for physical health and a 26.71 percent increase for behavioral health. UnitedHealthcare (UHC) reported an overall 81 percent increase.

PCMH results suggest BCBSNM increased members by 35.4 percent, MHNM by 28.9 percent, PHP by 52.7 percent, and UHC by 36.5 percent. PHP is the only MCO to meet a 40 percent minimum, and is expected to maintain a 40 percent minimum.

ED Diversion results indicate two MCOs met the target and two did not. PHP and UHC did not meet the required 10% reduction of non-emergent emergency room use. PHP had an overall reduction of 5.2% and UHC had an overall reduction of 7.7%. BCBS exceeded the 10% reduction with a 14.6% overall reduction and MHNM had a 14.3% reduction in overall non-emergent emergency room use.

Once analysis is complete, the Delivery System Improvement Fund shall be released to MCOs for each successfully met target.

8. Community Health Workers

New Mexico has a long tradition of relying on trusted community members to support and educate their neighbors on health-related issues. In New Mexico, where 32 of the state's 33 counties are designated by the Health Resources and Services Administration as health professional shortage areas for primary care, community health workers (CHWs) are frontline public health workers who are trusted members of the communities they serve. This trusting relationship enables the CHW to serve as a liaison, link or intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

CHWs are being utilized in Centennial Care to address population health issues and supplement primary care, specifically by improving health and health care literacy, establishing member linkages to community supports, and supporting care coordination. The Centennial Care MCOs are required to make CHWs available to their members, and specifically report using CHWs to:

- Educate referred members about alternatives to emergency room use;
- Locate members to obtain HRAs;
- Ensure that members have the required basic life necessities to remain healthy and safe;
- Assist members with making and keeping health care appointments and arranging transportation, if needed;
- Refer members to local resources found within communities (i.e., food pantries, utility assistance and housing);
- Provide wellness support;
- Locate unreachable members for care coordination; and
- Provide translation services.

In addition, the state has partnered with the University of New Mexico (UNM) and a rural FQHC to develop a pilot program, called CHISPAS (Community Health Improvement through Strengthened Partnership, Access and Support), in collaboration with the Centennial Care MCOs. This pilot leverages the Centennial Care, care coordination program by implementing three levels of Medicaid patient support through the deployment of CHWs. The three levels of Medicaid patient support include:

- Community Health Improvement (Level 1) – addressing local policy, system and environmental change to improve underlying causes of ill health.
- Patient Support (Level 2) – stopping the further progression of disease and ensuring access to preventive services.

- Intensive Care Coordination (Level 3) – concentrated support for high-risk and high-cost members, in terms of specific intervention strategies that are urgent and designed to improve health and reduce costs through the development of individualized plans and 100% case review.

New Mexico rolled out the CHISPAS pilot in State Fiscal Year (SFY) 2015, with the goal of further evaluation and dissemination/replication to other counties in the state in SFY15. The pilot model includes a robust evaluation design that includes Return on Investment (ROI) parameters. The results of the evaluation will be available for reporting and dissemination in July 2016.

B. Project Status

The demonstration project has moved from its implementation phase in DY1 to steady state in DY2 where the focus has been on performance. In DY3, HSD's goal is to focus on slowing the growth rate of healthcare costs while improving health outcomes. In order to progress in achieving these goals, HSD and MCOs tasks will be to: implement value-based purchasing that promotes integration of services, reduces costs, and increases quality of care; reduce service gaps through innovative delivery models that build provider capacity, collaborate with partners to support prevention models and reduce health disparities; implement person-centric service models, including streamlining and enhancing access and engagement of members; and, improving administrative effectiveness and simplicity.

1. Care Coordination

In Centennial Care, all members receive a health risk assessment (HRA) to determine care coordination level 1 or the need for a comprehensive needs assessment (CNA) to assess physical, behavioral and long-term care (LTC) needs and receive a person-centered care plan.

Care coordination level 2 members receive semi-annual in-person visits, quarterly telephone contact, and an annual CNA to determine if the level of coordination and care plan are appropriate. Care coordination level 3 members receive monthly telephone contact, quarterly in-person visits and a semi-annual CNA to determine if the level of coordination and care plan are appropriate.

Other care coordination highlights in 2015 included:

- 40 percent of the Centennial Care members are being served in a Patient Centered Medical Homes;
- 10% of enrollees are in higher levels of care coordination;
- MCOs are partnering with community agencies, such as Albuquerque Ambulance and Kitchen Angels, to conduct home visits for super utilizers;

- HSD staff recently conducted a series of new trainings for care coordinators to improve identification of behavioral health needs and assessment for members with a brain injury. Staff also held trainings to better educate coordinators about available community benefit services; and
- The MCOs collaborated to design a standard health risk assessment that will be used across the system by all MCOs.

C. **Utilization Data**

Attached is Centennial Care key utilization and cost per unit data by overall program as well as by specific program for CY 2014 and January through June of 2015. Due to claims lag, full CY 2015 is not yet available but will be submitted with next CMS quarterly report. Please see Attachment F – Key Utilization/Cost per Unit Statistics by Major Population Group.

D. Progress on Implementing Payment Reform Initiatives

HSD implemented several initiatives under the Centennial Care program during 2015 that are designed to contain costs while also improving health outcomes. While it is too early to see the results of some of these initiatives, HSD remains confident that they will ultimately be successful on both of these measures. New Mexico's vision is that the most successful and viable Centennial Care payment reforms – based on an evaluation of quality, cost and efficiency – will be leveraged across the Medicaid delivery system in the fourth and fifth years of the Centennial Care waiver.

1. MCO Projects

HSD evaluated payment reform project proposals from each of the MCOs and approved at least one project for each MCO to begin by July 1, 2015. Several MCOs have implemented an accountable care organization (ACO) or ACO-like project with large provider groups. The projects build on existing efforts to move away from volume-based payments and, if they prove successful in improving quality and lowering costs, will be scaled up and implemented statewide. HSD will continue to work with the MCOs to broaden these projects over time to progress from pay-for-performance initiatives to more fully developed shared-risk arrangements. A summary of the payment reform projects is below:

Table #11 – Payment Reform Projects

Project	P4P/ ACO	Bundled Pay	Description
Accountable Care –Like Models	X		Accountable Care Organization (ACO) model with shared savings for improving quality and reducing total cost of care.
Bundled Payments for Episodes		X	Pursuing bundles for diabetes, bariatric, and maternity.
Emergency Room and Inpatient Reduction Incentives with Behavioral Health Focus	X		Piloting with CSA to reduce ER and inpatient through intensive follow-up, use of peer specialists, crisis visits, and PCP coordination.
Three-tiered Reimbursement for Patient Centered Medical Homes (PCMHs)	X		PMPM increases for base care coordination; data transfer to HIE; telehealth; use of EHRs; and performing HRAs. A total performance incentive per member payment is possible if the targets for every measure are met.
Bundled Payments for Targeted Inpatient Admission Episodes		X	Bundle payments for pneumonia and colonoscopies.
Obstetrics Gain Sharing	X		Reducing unnecessary primary C-sections by developing savings targets that reward appropriate use of C-sections. Under this program, obstetricians can earn enhanced fees for meeting metrics related to reducing unwarranted C-sections.

2. Centennial Member Rewards Program

Centennial Rewards, the waiver's beneficiary engagement program, was also successfully launched during 2014. As in payment reform, time is still needed to see if the costs for this program are more than offset by changes in beneficiary behavior that leads to lower costs and healthier members.

- The member rewards program was developed to encourage members to become more active participants in their healthcare.
- In demonstration year two (DY2), $14.7 million in rewards were earned.
- In DY2, $4.7 million in rewards were redeemed.

- Members earn rewards by making healthy choices, such as:
    - Annual dentist visit;
    - Joining their MCO's prenatal program;
    - Managing asthma through controller refills;
    - Managing diabetes through getting the appropriate tests and examinations; and
    - Managing certain BH conditions through medication refills.

E. Policy and Administrative Difficulties in Operating the Demonstration

The State identified accuracy issues with the setting of care information that was submitted by MCOs. The setting of care is important because it drives the MMIS assignment of the members' enrollment and the MCOs' capitation payments. Only those members receiving long term care services and supports (LTSS) must have a setting of care. The State has been working to identify the root causes with the MCOs as well as conducting analysis of historical data submissions. In addition, the EQRO contractor audited level of care assessments performed by the MCOs before proceeding with any type of data reconciliation activities. The State's actuary will perform enhanced analysis of the data to ensure that any anomalies are addressed before developing the LTSS rates. This has resulted in a delay in the development of the new LTSS rates. The State is addressing this issue with the MCOs by adding new contract language regarding the entry of setting of care spans. Additional training has been provided to the MCOs and the State will continue to monitor setting of care changes.

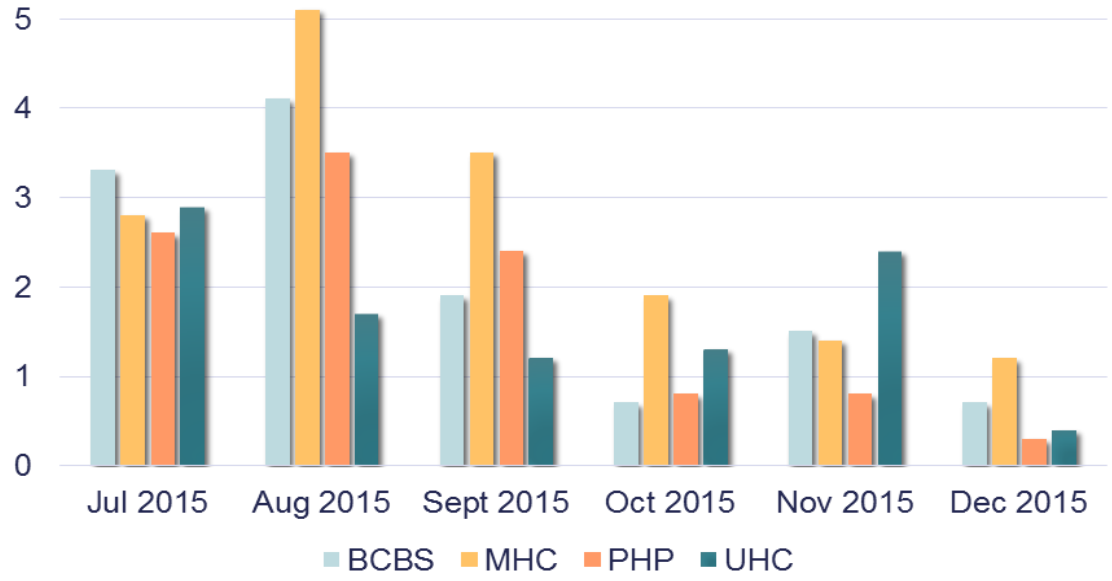
F. Outcomes of Focused Studies

1. Super Utilizer Project

HSD is utilizing PRISM software to track members who are high utilizers of the Emergency Department (ED) and work with the MCOs on implementing interventions to reduce ED utilization.

- PRISM is an integrated software tool used to support care management interventions for high risk Medicaid patients.
- HSD utilized PRISM data to identify the MCOs' highest utilizers of the Emergency Department (ED) over a 15 month period.
- HSD reviewed the top 10 members for each MCO.
- The MCOs developed recommendations for better management of super utilizers.
- The following graph illustrates progress in ED reduction for the top 10 super utilizers with each MCO:

Table #12 – Reduction in Number of ED Visits for Super Utilizers



2. Other MCO Efforts to Reduce Non-emergent Emergency Room Use

The MCOs formed a workgroup to develop initiatives to reduce non-emergent ER use:

- Assigning Community Health Workers to high utilizers;
- Piloting programs with Emergency Medical Technicians to visit members;
- Purchasing EDIE software for instant notification when a member is in the ER;
- Patient Navigator program contacted by hospital to triage members and direct them to more appropriate setting such as Urgent Care;
- Video physician visits have been implemented by all MCOs with ability to assess through an app on smart phones.

G. CAHPS Survey

Centennial Care MCOs are required to submit the Consumer Assessment of Healthcare Providers and Systems (CAHPS) results report on an annual basis with data collected from the prior year. HSD worked with the MCOs to ensure the quality of the data collected through the survey and inclusion of questions that would capture data for all Centennial Care members.

In November 2013 HSD required the MCOs to include 10 additional supplemental questions on the CAHPS survey for 2015. The supplemental questions were approved by the National Committee for Quality Assurance (NCQA). With HSD direction, the MCOs focused on how to manage the CAHPS survey project, provide a valid sample of applicable members, collect adequate data, review and analyze data as available and work to compile the required CAHPS report.

In April 2014 HSD added 4 additional questions to the survey for a total of 14 supplemental questions for 2015. NCQA approval for the 4 supplemental questions was not received until December 2015 resulting in some MCOs excluding them in the survey for 2015.

United Healthcare (UHC) did not add any of the supplemental questions into the CAHPS survey for 2015. The reason given by UHC was an internal miscommunication that prevented the inclusion of the additional questions. In addition, some of the CAHPS questions were not answered in the child care coordination section due to miscommunication between UHC and HSD.

HSD received the MCOs' CAHPS results for 2015. HSD reached out to the MCOs and provided the technical assistance and the additional guidance needed to ensure reporting of supplemental questions in future CAHPS surveys.

HSD worked with NCQA on the approval of all State required questions for 2016. NCQA approved four supplemental questions surveying fall risk which will be added to the CAHPS survey for 2016. HSD will continue to work closely with the MCOs on implementing the State required supplemental questions into the survey and to collaboratively collect, review and analyze adequate data. The 2016 CAHPS survey is due to HSD in October 2016.

Below is a table with the supplemental questions and results submitted for 2015.

Table #13 – CAHPS Scores by MCO

CAHPS Supplemental Questions	BCBS		PHP		MHC		UHC
Child Care Coordination *CCC-Children with Chronic Conditions *N/A- Not Reported							
In the last 6 months did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these doctors or other health providers? (% of Yes)	27 %	39 % CCC	24 %	44 %CCC	24 %	44 %CCC	N/A
In the last 6 months, who helped to coordinate your child's care? (% of Yes)							
Someone from your child's health plan	4%	8% CCC	4%	9% CCC	14 %	13 %CCC	N/A
Someone from your child's doctor's office or clinic	19 %	22 %CCC	48 %	50 %CCC	48 %	55 %CCC	N/A
Someone from another organization	1%	4% CCC	6%	7% CCC	10 %	6% CCC	N/A
A friend or family member	5%	6%	3%	3%	1%	1%	N/A

		CCC		CCC		CCC	
You	71 %	60 %CCC	39 %	31 %CCC	27 %	25 %CCC	N/A
How satisfied are you with the help you got to coordinate your child's care in the last 6 months?							
Satisfied	19 %	19 %CCC	45 %	46 %CCC	43 %	40 %CCC	N/A
Very Satisfied	61 %	55 %CCC	48 %	40 %CCC	43 %	48 %CCC	N/A
Member Education							
In the last 6 months, have you received any material from your health plan about good health and how to stay healthy? (% of Yes)	69 %	68 %CCC	71 %	73 %CCC	N/A		N/A
In the last 6 months, have you received any material from your health plan about care coordination and how to contact the care coordination unit? (% of Yes)	61 %	61 %CCC	N/A		N/A		N/A
Care Plan							
Did your care coordinator sit down with you and create a plan of care? (% of Yes)	14 %	21 %CCC	50 %	60 %CCC	N/A		N/A
Are you satisfied that your care plan talks about the help you need to stay healthy and remain at you home? (% of Yes)							
Satisfied	25 %	29 %CCC	45 %	48 %CCC	N/A		N/A
Very Satisfied	44 %	43 %CCC	46 %	40 %CCC	N/A		N/A
Adult Care Coordination *N/A-Not Reported							
In the last 6 months did anyone from your health plan, doctor's office, or clinic help coordinate your care among these doctors or other health providers? (%of Yes)	33%		27%		24%		N/A
In the last 6 months, who helped to coordinate your care? (% of Yes)							
Someone from your child's health plan	9%		17%		19%		N/A
Someone from your doctor's office or	25%		47%		48%		N/A

clinic				
Someone from another organization	2%	4%	3%	N/A
A friend or family member	14%	13%	16%	N/A
You	50%	19%	0%	N/A
How satisfied are you with the help you got to coordinate your care in the last 6 months? (% of Yes)				
Satisfied	23%	43%	40%	N/A
Very Satisfied	57%	47%	47%	N/A
Member Education				
In the last 6 months, have you received any material from your health plan about good health and how to stay healthy? (% of Yes)	58%	62%	59%	N/A
In the last 6 months, have you received any material from your health plan about care coordination and how to contact the care coordination unit? (% of Yes)	50%	50%	48%	N/A
Care Plan				
Did your care coordinator sit down with you and create a plan of care? (% of Yes)	24%	50%	24%	N/A
Are you satisfied that your care plan talks about the help you need to stay healthy and remain at you home? (% of Yes)				
Satisfied	25%	N/A	41%	N/A
Very Satisfied	44%	N/A	30%	N/A
Fall Risk				
A fall is when your body goes to the ground without being pushed. In the last 12 months, did you talk with your doctor or other health provider about falling or problems with balance or walking? (% of Yes)	22%	22%	18%	N/A
Did you Fall in the past 12 months? (% of Yes)	19%	17%	18%	N/A
In the past 12 months, have you had a problem with balance or walking? (% of Yes)	27%	25%	24%	N/A
Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? (% of Yes)	23%	26%	23%	N/A

H. **Annual Summary of Network Adequacy by Plan**

Each MCO has policies and processes in place to closely monitor and evaluate network adequacy and make adjustments as necessary. Each MCO provides an annual Provider Network Development and Management Plan and evaluation to look retrospectively at the prior year and forward into the coming year. The MCOs' plans address provider adequacy to ensure accessibility and availability for medically necessary, covered services for its existing members and as well as projected utilization that includes potential membership

growth. HSD evaluates and provides feedback to the MCOs on these evaluations and plans.

As primary components to inform their decisions, MCOs utilize Report #3, the Provider Adequacy Report, to evaluate provider ratios and Report #55, the GeoAccess Report, to evaluate distance requirements to providers and how well they are meeting the standard. HSD tracks the progress of each MCO in meeting GeoAccess standards quarter-over-quarter and focuses on improvements to distance requirements where standards are not being met. Please also see Attachment E – 2014-15 GeoAccess PH.

- In most instances, BCBSNM maintained the 90% standard of members meeting distance requirements to providers, and in some cases, percentages have improved significantly. For dermatology, endocrinology and rheumatology, BCBSNM made some progress in improving access. In DY2 Q3, BCBSNM improved sufficiently to meet the 90% standard of members meeting distance requirements in hematology/oncology and neurology in rural areas.

- UHC meets distance requirements for all provider types in urban areas, including dermatology.

- In rural areas, there are five specialties for which UHC does not meet distance requirements, however, these are all specialties with provider shortages, and neurosurgery is close to the standard at 89.4%. In frontier areas, UHC meets distance requirements for endocrinology and the same provider types with shortages in rural areas are seen in frontier areas as well. The percentage of members meeting distance requirements to providers types with shortages in rural and frontier areas have been slightly improved over time.

- In general, MHNM has improved its access percentages for several provider types in DY2 as compared to DY1. While MHNM improved access to neurology, it fell below the standard in rheumatology. MHNM recently self-identified some reporting errors and resubmitted GeoAccess reports for each quarter in DY2.

- PHP has been consistent quarter-over-quarter with its member-to-provider percentages meeting distance standards. There was a slight drop in endocrinology from 76.7% to 69.4% in rural areas and an improvement from 81.3% to 86.7% in frontier areas. PHP meet the distance standard for neurology in Q2 DY2 for rural areas and in Q3 DY2 for frontier areas.

The measure for access to FQHCs in frontier areas fell below 90% in Q2; however, the percentage of members who meet the distance requirements remains high at 86.4 %.

See also Section II. B. for additional information on provider access.

I. Summary of Outcomes of Onsite Reviews

1. Myers & Stauffer Evaluation

As noted in the DY2 Q4 report, Myers and Stauffer was engaged to assist HSD with monitoring and reporting of the MCOs' performance under Centennial Care. Myers and Stauffer staff reviewed each MCO's systems and processes as they related to: paid and denied inpatient hospital claims for areas of claims adjudication, prior authorization, and provider credentialing. A summary of findings and resulting actions and activities will be reported in the DY3 Q1 report.

2. Compliance Audit

HSD contracted with HealthInsight as the EQRO to conduct the Compliance Audit of Centennial Care Contracted MCOs. Pursuant to CMS EQR protocol 1 guidelines, each MCO was assessed for compliance with state and federal regulations.

The review measured each MCO's level of compliance with contractual and regulatory requirements of Centennial Care. HealthInsight's evaluation included two sections:

- Evaluation of each MCO's policies, procedures and other documentation
- Examination of medical records and case files

EQRO evaluation activities consisted of a review of all documentation submitted by each MCO, and a four day site visit consisting of a medical record review and interviews with key MCO staff. The table below presents category specific and overall scores for each MCO.

Table #14 – Compliance Audit Scores

Each Scored Subject, by MCO				
Subject	**B**CBS	**MHP**	**PHP**	**UHC**
Enrollment/Disenrollment	100.00%	100.00%	100.00%	100.00%
Member Handbook	100.00%	100.00%	100.00%	100.00%
Member Materials	100.00%	100.00%	100.00%	100.00%
Member Services	100.00%	100.00%	100.00%	100.00%
Program Integrity	95.80%	94.40%	100.00%	98.60%
Provider Network	100.00%	100.00%	100.00%	100.00%
Provider Services	100.00%	100.00%	100.00%	100.00%
Reporting Requirements	100.00%	100.00%	100.00%	100.00%
Self-Directed Community Benefits	100.00%	100.00%	100.00%	100.00%
Utilization Management Approvals	91.00%	100.00%	78.72%	100.00%
Utilization Management Denials	99.67%	97.67%	96.00%	100.00%
Care Coordination	87.40%	96.70%	99.00%	96.00%
Transition of Care	100.00%	100.00%	100.00%	100.00%
Grievances and Appeals	99.30%	99.60%	99.30%	99.46%
Maintenance of Medical Records	96.78%	95.78%	96.22%	92.00%
PCP and Pharmacy Lock-Ins	100.00%	100.00%	78.75%	62.50%
Overall Score	**97.80%**	**98.89%**	**96.91%**	**95.55%**

J. Summary of Performance Improvement Projects

Pursuant to the Centennial Care Contract, MCO Performance Improvement Projects (PIPs) in waiver year two focused on the following areas:

- Long Term Care (LTC) services
- Services to children
- PIPs as required by the CMS Adult Medicaid Quality Grant (AMQG)

Table #15 – Non-AMQG PIPs by MCO for 2015

BCBS	MHC	PHP	UHC
Attention to dental health for children	Identification of obese members among School Based Health Clinics ages 12-17	Use of appropriate medication for children with Asthma	Targeted interventions for eligible children receiving dental exams
Recommended yearly diabetic eye exams for long-term facility resident members	Interventions for long term services members with at least one fall event	Inter-Rater reliability for personal care services allocation	Target members 21 years and older referred for an assessment to transition from a nursing facility to a home and community based setting.

HSD has contracted with HealthInsight as the External Quality Review Organization (EQRO) to assess measure and validate non-AMQG PIPs listed in the above table. The EQRO reviewed the PIPs projects for each of the MCOs and determined the projects listed

were in full compliance with Centennial Care contractual requirements.

The two PIPs managed through the CMS AMQG were:

1. Prevention and enhanced disease management for diabetes
    - Diabetes, short-term complications admission rate.
    - Comprehensive diabetes care: low density lipoprotein-cholesterol (LDL-C).
    - Comprehensive diabetes care: hemoglobin A1c testing.
2. Screening/management for clinical depression
    - Antidepressant medication management.
    - Screening for clinical depression and follow-up plan.

HSD observed the following results for each of the focused areas:

1. Prevention and enhanced disease management for diabetes
    - Diabetes, short-term complications admissions rate: Fluctuation among the MCOs noted with two improving in the 18-64 age groups and two improving in the 65 and older group.
    - Comprehensive diabetes care LDL-C testing: MCO expected performance was not met for this measure. This decline in performance can be attributed to Healthcare Effectiveness Data Information Set (HEDIS) retiring LDL testing for diabetics in 2015.
    - Comprehensive diabetes care hemoglobin A1c testing: Improvements were noted with three MCOs improving in the 18-64 age groups and two improving in the 65 and older group.
2. Screening/Management for clinical depression and follow up plan
    - Antidepressant medication management: Overall improvements were noted in the 18-69 age groups and 65 and older group.
    - Screening for clinical depression and follow-up plan: Fluctuations among the MCOs noted with two improving in the 18-64 age groups and three improving in the 65 and older group.

The AMQG ended in December 2015. To keep the goals of the grant sustainable beyond the end of the grant, HSD has incorporated these PIPs into the Centennial Care contract effective January 1, 2016.

K. Outcomes of Performance Measure Monitoring

The baseline years for setting future targets and thresholds for all Centennial Care performance and tracking measures are 2014 and 2015. HSD has included eight HEDIS-based performance measures (PMs) into the Centennial Care contract that will be tracked by the EQRO. The eight PMs are as follows:

- PM#1-Annual dental Visit
- PM#2-Use of appropriate medications for people with asthma
- PM#3-Controlling high blood pressure
- PM#4-Comprehensive diabetes care – HbA1c testing
- PM#5-Timeliness of prenatal and postpartum care
- PM#6-Frequency of on-going prenatal care
- PM#7-Antidepressant medication management
- PM#8-Follow-up after hospitalization for mental illness

The PMs have a continuous enrollment requirement of greater than or equal to 365 days. HSD has contracted with HealthInsight as the External Quality Review Organization (EQRO) to assess performance measures. EQRO review rated each MCO's performance management programs in full compliance with Centennial Care contractual requirements.

The EQRO reviewed and rated each MCO according to External Quality Review (EQR) CMS protocol 2. Performance rates reported represent members during calendar year 2014. MCO performance rates are compared with average rates reported from the Department of Health and Human Services Region V1.

Table #16 – MCO Performance Measures

MCO Performance Measures	BCBS	MHP	PHP	UHC	Regional Average
Annual dental visit					
Ages 2-21	57.46	62.75	**68.14**	41.52	44.52
Use of appropriate medications for people with asthma					
Ages 6-11	**91.59**	89.84	91.06	NR	91.55
Ages 12-18	**84.85**	84.40	79.41	NR	88.36
Controlling high blood pressure					
Ages 18-86	51.66	49.88	**55.95**	53.04	46.59
Comprehensive diabetes care					
Eye Exam	54.23	56.51	47.75	**65.21**	46.64
HbA1c Testing	83.42	85.65	**86.52**	84.43	82.55
Medical Attention for Nephropathy	78.61	74.83	79.53	**83.70**	77.04
Poor HbA1c Control (Inverse rate/lower is better)	47.26	49.89	**43.93**	49.15	56.70
Prenatal and postpartum care					

Timeliness of (initiating) prenatal care	73.08	76.80	**77.88**	63.75	84.64
Completion of postpartum visit	54.52	54.50	**61.88**	48.18	58.01
Frequency of ongoing prenatal care					
Completed more than 80% of anticipated visits	55.20	**61.04**	48.71	42.58	60.47
Antidepressant medication management					
Effective acute phase treatment	59.97	53.50	53.94	**62.50**	49.28
Effective continuation phase treatment	47.77	38.63	38.97	**48.34**	33.97
Follow-up after hospitalization for mental illness					
7-days after discharge	39.00	41.80	43.14	**55.16**	42.70
30-days after discharge	58.49	64.80	67.88	**71.00**	64.03

Bolded text: Bolded text indicates the highest performance rates reported in N.M.
Greyed areas: Greyed areas indicate performance rates below Regional Averages.

L. Annual Consumer and Family/Caregiver Satisfaction Survey

HSD conducts an annual consumer, family/caregiver, and youth satisfaction survey for Centennial Care members identified with BH needs. This is a joint effort between CYFD, HSD, and the four MCOs. The results are used to identify areas for service improvement.

The Survey reports on seven domains that are then able to be compared with national data. The seven domains are:

- Access
- Participation in Treatment
- Improved Functioning
- Social Connectedness
- Quality and Appropriateness
- Cultural Sensitivity Outcomes
- Overall Satisfaction

Please see Attachment G – Satisfaction Survey, for more information and findings from DY2.

M. **Summary of Plan Financial Performance**

HSD's analysis of quarterly financial reports raised questions and issues around Nursing Facility Level of Care (NFLOC) and Setting of Care (SOC) determinations and timely NFLOC and SOC span submissions. With NFLOC and SOC spans updated in the MMIS system, HSD reconciled all SOC submissions for retrospective spans of time in 2016 and 2014 for the long term care programs. HSD processed all related retrospective capitation payments/recoupments which affected all programs. With the completion of the system and payment reconciliations, MCOs were asked to resubmit the CY2014 annual supplement financial reports for all programs (PH, BH, LTSS, OAG-PH, OAG-BH). HSD's analysis of the resubmitted CY14 financial reports will focus on the reclassification of LTSS and OAG

members and their corresponding claims/expenses to the appropriate program/cohort/SOC as well as consistent and uniform reporting by all MCOs.

All MCOs submitted their CY2015 fourth quarter financial reports on the due date of February 15, 2016. HSD's attention will continue to be focused on the categorization of members and their corresponding claims/expenses to the appropriate program/cohort/SOC within the financial reports. Also, HSD is working to reconcile the data in the financial reports to MCO encounter data. MCOs have been asked to submit a standing Ad Hoc report that will aid in the analysis of financial and encounter data.

Currently, HSD is in the process of performing the various reconciliations that are required under the Centennial Care contract for CY2014 and CY2015. The CY2015 annual supplement financial reporting is due in mid-May 2016. The annual reporting will include a reconciliation and explanation of the calendar year estimates used as part of its accrual method of accounting. In an effort to increase efficiency, HSD will utilize the information provided within the financial reports, applicable programmatic reports as well as MCO encounter data to evaluate financial and operational performance at both individual MCO level and an aggregate level.

N. Analysis of Service Reductions through the Service Planning Process

Any reduction, suspension, denial or termination of previously authorized HCBS services for a member under a section 1915(c) waiver who transitioned to Centennial Care and continued to meet Nursing Facility Level of Care had to be reviewed by HSD for the first 6 months of 2014. HSD approved two of seven requests for that first six month period. The annual review for Calendar Year 2014 Service Plan Reductions included 16 member chart reviews. All reductions were justified with the documentation found in the review indicating an increase in member abilities or refusal by member due to preference for use of natural supports.

Section VI: Summary of Quality of Care/Health Outcomes for AI/AN Beneficiaries

During the second year of the waiver, data indicated that all MCOs had increases for Native Americans to specialty care visits for cardiology, orthopedic visits, and Licensed Professional Clinical Counselors. All Centennial Care MCOs are striving to increase the numbers of HRAs completed in 2015 for Native Americans, some by partnering with tribal organizations to find "unable to locate" members. The MCOs are also working to increase attendance at their NAAB meetings. All MCOs have extended invitations to tribal leadership for their NAAB meetings.

In the second waiver year, three of the four MCOs saw decreased medical admissions rates for Native Americans. The average length of stay also decreased by 60 percent during 2015. The following chart outlines the top 10 Community Benefits utilized during the first half of 2015 (January 1st through June 30th).

Table #17 – Highest Utilized Community Benefit Services by Native Americans

Rank	Procedure Code Description
1	Personal Care (per hour)
2	Personal Care-Directed Admin Fee (unit + month)
3	Environmental Modification (per project)
4	Assist Living (per month)
5	Related Goods including sales taxes
6	Personal Care-Directed training (15 min)
7	Non-Medical Transportation (trips, passes, miles)
8	Emergency Response (month)
9	Adult Day Health (15 min)
10	Private Duty Nursing for Adults-LPN (15 min)

For BH services in frontier areas, all four MCOs met the access to services targets by 80 percent or more. For PH services, three of the four MCOs met access to care by 80 percent or more in frontier areas.

In WY2, frequently accessed value added services by Native American members included traditional healing, educational/incentive programs for pregnant women, dental varnish, and additional vision services. One MCO offered a value added service of sleep studies that had high utilization. Another MCO offered an upgraded transportation benefit that was frequently utilized by its Native American members.

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

A. Native American Advisory Meetings

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

- Advise the Medicaid program about how to best serve the tribal communities and Native American Centennial Care members on resolution of issues with MCOs and to facilitate successful reimbursement and reduce administrative burden; and
- Address issues related to enrollment, access to care and payment for services and review of program data.

The MCOs are also required to conduct individual MCO quarterly Native American Advisory Board (NAAB) meetings to address issues related to benefits, access and delivery of services, and other concerns specifically related to Native American enrollees.

Table #18 – Schedule of DY2 NAAB Meetings

MCO	Location/Date of Board Meeting	Issues/Recommendations
UHC	Bernalillo, NM 3/5/15	UHC has proposed to partner with the NM Indian Affairs Department (IAD) for their next NAAB meeting. They will work with I/T/Us, Tribal administrators, and health directors to increase membership at the NAAB meetings. One concern is the lack of Native American members at their NAAB meetings.
MHNM	Albuquerque, NM 3/18/15	Molina offers Native American Advisory Board meetings quarterly to providers as well as members. They have a high turnout of members at their meetings. At their last Native American provider board meeting they focused on care coordination, self -directed and agency based community benefits.
PHP	Albuquerque, NM 3/20/15	Members suggested that the HRAs be standard for all MCOs and that PE determiners give the HRA to members when they are approved for Medicaid. Tohajiilee wants to pursue a partnership agreement with PHP for BH services. I/T/U providers requested more training on Centennial Care billing (which PHP scheduled for the following month).

MCO	Location/Date of Board Meeting	Issues/Recommendations
BCBSNM	Zuni Pueblo, NM 3/26/15	BCBSNM held their first quarter meeting at the Tribal Administration at Zuni Pueblo which resulted in many more attendees, including Tribal leadership. They plan to schedule future advisory board meetings in Tribal communities.
MHNM	Gallup, NM 5/08/15	MHNM had a very large turnout at this event (well over 60 people). MHNM answered questions on care coordination, MHNM providers in the Gallup area, prescriptions, and Centennial Rewards.
UHC	Farmington, NM 6/04/15	There were around 14 providers present for this NAAB meeting. There were guest speakers from the American Cancer Society, Logisticare (transportation vendor), and a Traditionalist from First Nations Community Healthsource.
BCBSNM	Crownpoint, NM 6/10/15	BCBSNM held their second quarter NAAB meeting at the Crownpoint Chapter House. About 35 people were in attendance. Good audience participation and interaction. No concerns.
PHP	Gallup, NM 6/19/15	PHP presented on their traditional healing benefit and explained how care coordination works. About 15 people attended the meeting.
BCBSNM	Acoma/Laguna/Canoncito Hospital San Fidel, New Mexico 8/12/15	About 17 participants attended. BCBSNM presented on the Centennial Rewards program, (alternative benefits plan (ABP) benefits, and answered questions.
UHC	Mescalero Apache Tribal Offices Mescalero, New Mexico 9/3/15	There were about 14 providers at the UHC NAAB meeting. UHC had guest speakers from the American Cancer Society and Logisticare (transportation vendor). There was also good turnout by Tribal members and Tribal leadership.
MHNM	Santa Fe Indian Hospital Santa Fe, New Mexico 9/22/15	Twelve members attend this meeting. MHNM answered questions about care coordination, the traditional healing benefit, and how to access services.
PHP	Jemez Pueblo, New Mexico 9/25/15	PHP presented on their services and focused on care coordination. About 6 people attended the meeting.

MCO	Location/Date of Board Meeting	Issues/Recommendations
UHC	Farmington, NM November 10, 2015	UHC had about 20 providers at their NAAB meeting. There was discussion on care coordination, benefits and services, and a discussion on how UHC can improve their services (suggestions for future value added services).
BCBSNM	Shiprock Chapter House Shiprock, NM 11/13/15	BCBSNM held their NAAB meeting at the Shiprock Chapter House. About 47 participants attended. BCBSNM went over their Centennial Care rewards, ABP benefits, and answered questions regarding transportation, doctors out of state, and care coordination.
MHNM	Upper Fruitland Chapter House Upper Fruitland, NM 11/14/15	About 57 participants attended this meeting. The audience had questions about transportation, if MHNM pays for out of state trips, ramps, wheelchairs, and car seats. Suggestion that future meetings have a larger space, no children at the meeting, and notebooks. The meeting was translated in Navajo.
PHP	Lincoln County Medical Center Ruidoso, NM 12/3/15	About four providers from IHS attended the meeting. PHP presented on their services and focused on how care coordination works. They also talked about Presbyterian's Financial Assistance Policy for non-insured people needing help with medical bills.

Section VII: Quality Strategy/HCBS Assurances

A. Quality Strategy

Several quality initiatives continue to be performed and implemented the Centennial Care program, including Care Coordination, tracking of performance measures, critical incidents reporting and extensive MCO reporting and monitoring by HSD. Many of the quality strategy activities have been previously explained in other sections of this report.

- Please refer to Section II. F. for information on the care coordination audits that took place in 2015.
- Please refer to Section V. N. for information on service plan reduction request reviews.
- HSD continues to review high NF LOC and community benefit NF LOC denials on a quarterly basis to ensure the denials were appropriate and based on NF LOC criteria. No concerns were identified in 2015. Please see Section II. F. for more information on NF LOC reviews and community benefit services reviews.
- In 2015, HSD and the EQRO finalized an external audit tool to be used by the EQRO starting in waiver year two. Please refer to Section V. K. for more information on performance measure monitoring.
- Please refer to Section II. C. for information on critical incidents monitoring.

B. HCBS Assurances

HSD uses the CMS approved Centennial Care Quality Strategy to monitor the HCBS assurances. There are four areas identified in the quality strategy.

1. Level of Care (LOC) Determinations

HSD continues to conduct audits of NF LOC determinations to ensure that members being served through the community benefit have been assessed to meet the required LOC for those services. Please refer to Section II. F. for more information on the NF LOC reviews.

2. Service Plans

To ensure that MCOs appropriately create and implement service plans based on members' identified needs, HSD conducts monthly audits of each MCO to ensure the appropriate implementation of community benefit service plans. Please refer to Section II. F. for more information on HCBS service plan audits.

3. MCO Credentialing and/or Verification Policies

HSD manages provider enrollment for Agency-Based Community Benefit (ABCB) service providers. All interested providers are required to submit an initial application and annual recertification's to HSD to demonstrate that all required provider qualifications are met. HSD ensures that ABCB providers have the appropriate licensure/certification from the appropriate credentialing body.

Once the provider is credentialed and approved by HSD, the MCOs are notified of the approval which allows the provider to enter into a contract for that approved service.

4. Health and Welfare of Enrollees

HSD ensures that the MCOs, on an ongoing basis, identify, address, and seek to prevent instances of abuse, neglect and exploitation (ANE). HSD monitors the CI database and MCO reports, follows-up on reports of ANE, and ensures that other agencies are notified as appropriate. HSD provides updates on these activities to CMS in the quarterly reports. Please refer to Section II. C. for the waiver year two report on adverse incidents.

Section VIII: State Contacts

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Section IX: Enclosures and Attachments

Attachment A: Budget Neutrality Spreadsheet
Attachment B: 2015 Value Added Services
Attachment C: 2016 Value Added Services
Attachment D: Contract Amendment #4
Attachment E: 2014-2015 GeoAccess PH
Attachment F: Key Utilization/Cost per Unit Statistics by Major Population Group
Attachment G: Satisfaction Survey